

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR		
ROLAND			FRANKLIN			August 30		1968 10 A M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		
Male		White		March 31, 1905		63 YRS.		MONTHS DAYS HOURS MIN.		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Delaware		USA				WICOMICO Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury			Peninsula General Hospital			Retired Minister		Ministry		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Wicomico		Salisbury		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		1352 Woodland Road	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Riley William Adkins			Elizabeth Elliott							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.		17. INFORMANT (Wife)					
No					1352 Address Woodland Road					
					Mrs. Bessie M. Adkins, Salisbury, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>metastatic C.A. lung</u> <u>153.3</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>153.3</u> (b) <u>C.A. - injured colon</u> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>within</u> <u>within</u>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>Significant colon - obstruction of colon</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
8-17-68		obstructed colon			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <u>6-29</u> , 19 <u>55</u> , to <u>8-30</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>8-30</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Earl L. Royer M.D.</u>					22c. DATE SIGNED Sept. 3 / 1968					
22d. PHYSICIAN'S NAME (Type) Dr. Earl L. Royer					22e. ADDRESS 409 Camden Ave., Salisbury, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		Sept. 3, 1968		Wicomico Memorial Park		Salisbury, Wicomico, Maryland				
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR DA SEP 4 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>				

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12208

CERTIFICATE OF DEATH

12218

1. DECEASED-NAME (Type or print) First Middle Last <i>Joseph H. Andrews Jr.</i>			2a. DATE OF DEATH Month Day Year <i>August 29 1968</i>			2b. HOUR <i>11 P.M.</i>			
3. SEX <i>MALE</i>		4. RACE <i>WHITE</i>		5. DATE OF BIRTH <i>DEC. 3, 1906</i>		6. AGE (In years last birthday) <i>61</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>VIRGINIA</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Wicomico</i> Md.			
10. CITY OR TOWN OF DEATH <i>Salisbury</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Peninsula General Hospital</i>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Hardware Employee</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Poultry</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>MARYLAND</i>		13b. COUNTY <i>WICOMICO</i>		13c. CITY OR TOWN <i>GIRDLETREE</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
14. FATHER'S NAME First Middle Last <i>JOSEPH H. Andrews Sr.</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>SARIE SHORT</i>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>NO</i>			16b. SOCIAL SECURITY NO. <i>220-12-2214</i>		17. INFORMANT Address <i>ELIZABETH M. ANDREWS, SAME</i>				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>recurrent myocardial infarction</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>arteriosclerotic heart disease</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>4109</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>24 hrs</i> <i>years</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>4201 vascular occlusion, left lower extremity</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>8-14</i> , 1968, to <i>8-29</i> , 1968, that (I) (we) last saw the deceased alive on <i>8-29</i> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>John G. Buckelew M.D.</i>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>8/29/68</i>			
22d. PHYSICIAN'S NAME (Type) <i>John G. Buckelew MD</i>				22e. ADDRESS <i>Pine Bluff Rd. Salisbury, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>9/1/1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>BAPTIST CEM.</i>		23d. LOCATION (City or Town) (County) (State) <i>GIRDLETREE MD.</i>			
24. FUNERAL DIRECTOR <i>Thomas F. Williams</i>				ADDRESS <i>Snow Hill, MD.</i>		25a. REC'D BY REGISTRAR DATE <i>SEP 3 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

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*[Faint, illegible handwritten text, possibly bleed-through from the reverse side of the page]*

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12209 13 Film 812245 REC 12219											
1. DECEASED-NAME (Type or print) <i>McKelvey</i> First Middle Last						2a. DATE OF DEATH Month Day Year <i>August 13 1968</i>			2b. HOUR M		
3. SEX <i>Male</i>		4. RACE <i>Negro</i>		5. DATE OF BIRTH <i>4/8/1904</i>		6. AGE (In years last birthday) <i>64</i> YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U S A</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Wicomico</i> Md.					
10. CITY OR TOWN OF DEATH <i>Salisbury-Peninsula General Hospital</i>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Retired</i>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>				13b. COUNTY <i>Somerset</i>		13c. CITY OR TOWN <i>Princess Anne</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Rt. 1, Box 109E</i>	
14. FATHER'S NAME First Middle Last <i>George Bailey</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Mary Hall</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO. <i>220-03-6218</i>		17. INFORMANT <i>Francie Bailey</i>		Address			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH CAUSED BY: IMMEDIATE CAUSE (a) <i>Stom negative septicemia + shock</i> <i>567.0</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>due to peritonitis + abscess</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Pericardial</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>72</i>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>576X</i>											
19a. DATE OF OPERATION <i>Aug. 8, 1968</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Peritonitis + abd. abscess</i>				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>yes</i>			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from <i>Aug. 6, 1968</i> , to <i>Aug. 12, 1968</i> , that (I) (we) last saw the deceased alive on <i>Aug. 12, 1968</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <i>Vicente R. Carag Jr. M.D.</i> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED <i>Aug. 14, 1968</i>					
22d. PHYSICIAN'S NAME (Type) <i>VICENTE R. CARAG JR. M.D.</i>						22e. ADDRESS <i>Peninsula Gen. Hosp.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>8/18/68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>St Paul</i>		23d. LOCATION (City or Town) (County) (State) <i>Mt Vernon Maryland</i>					
24. FUNERAL DIRECTOR <i>William H James Jr</i> ADDRESS <i>Princess Anne, Md</i>						25a. REC'D BY REGISTRAR DATE <i>AUG 16 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles J. ...</i>			

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# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil. Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 10-1. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										12220									
12210 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										12220									
1. DECEASED-NAME (Type or Print)			First RAY			Middle E.			Last BAKER			2a. DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 8-13-68 19			2b. HOUR 8 A M				
3. SEX Male		4. RACE White		5. DATE OF BIRTH 7-7-07		6. AGE (In years last birthday) 61 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.		2c. DATE PRONOUNCED DEAD Month 8 Day 13 Year 68 19			2d. HOUR 6 P M				
7a. BIRTHPLACE (State or foreign country) Maryland				7b. CITIZEN OF WHAT COUNTRY? Willards				8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>				9. COUNTY OF DEATH Wicomico				Md.			
10. CITY OR TOWN OF DEATH Willards				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) xx				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Maintenance				12b. KIND OF BUSINESS OR INDUSTRY County roads							
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Md.				13b. COUNTY Wicomico				13c. CITY OR TOWN Willards				13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
14. FATHER'S NAME First Tilton				Middle Baker				Last Janie				15. MOTHER'S MAIDEN NAME First Bowden				Middle Last			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) xx				(If yes give war or dates of service) xx				16b. SOCIAL SECURITY NO. 212-14-4100				17. INFORMANT Ella C. Baker Willards, Md.				ADDRESS			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 4109 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a). stating the underlying cause lost. (b) Arteriosclerotic heart disease DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden years							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 4201 Pulmonary emphysema.																			
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>											
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)											
21d. INJURY OCCURRED WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f. LOCATION Street or R.F.D. No. City or Town County State											
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>																			
ACTUAL SIGNATURE EXAMINER'S NAME (Type) Earl L. Royer, M.D. 409 Camden Ave., Salisbury, Md.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				22b. DATE SIGNED August 16, 1968											
23a. BURIAL, CREMATION, REMOVAL (Specify)				23b. DATE 8/16/68				23c. NAME OF CEMETERY OR CREMATORY Cooper				23d. LOCATION (City or Town) (County) (State) Willards Wicomico Md.							
24. FUNERAL DIRECTOR Watson & Whaley, Solbyville, Del.				25a. REC'D BY REGISTRAR DATE AUG 20 1968				25b. REGISTRAR'S SIGNATURE Charles Judge											

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THE UNIVERSITY OF CHICAGO

LIBRARY OF THE UNIVERSITY OF CHICAGO

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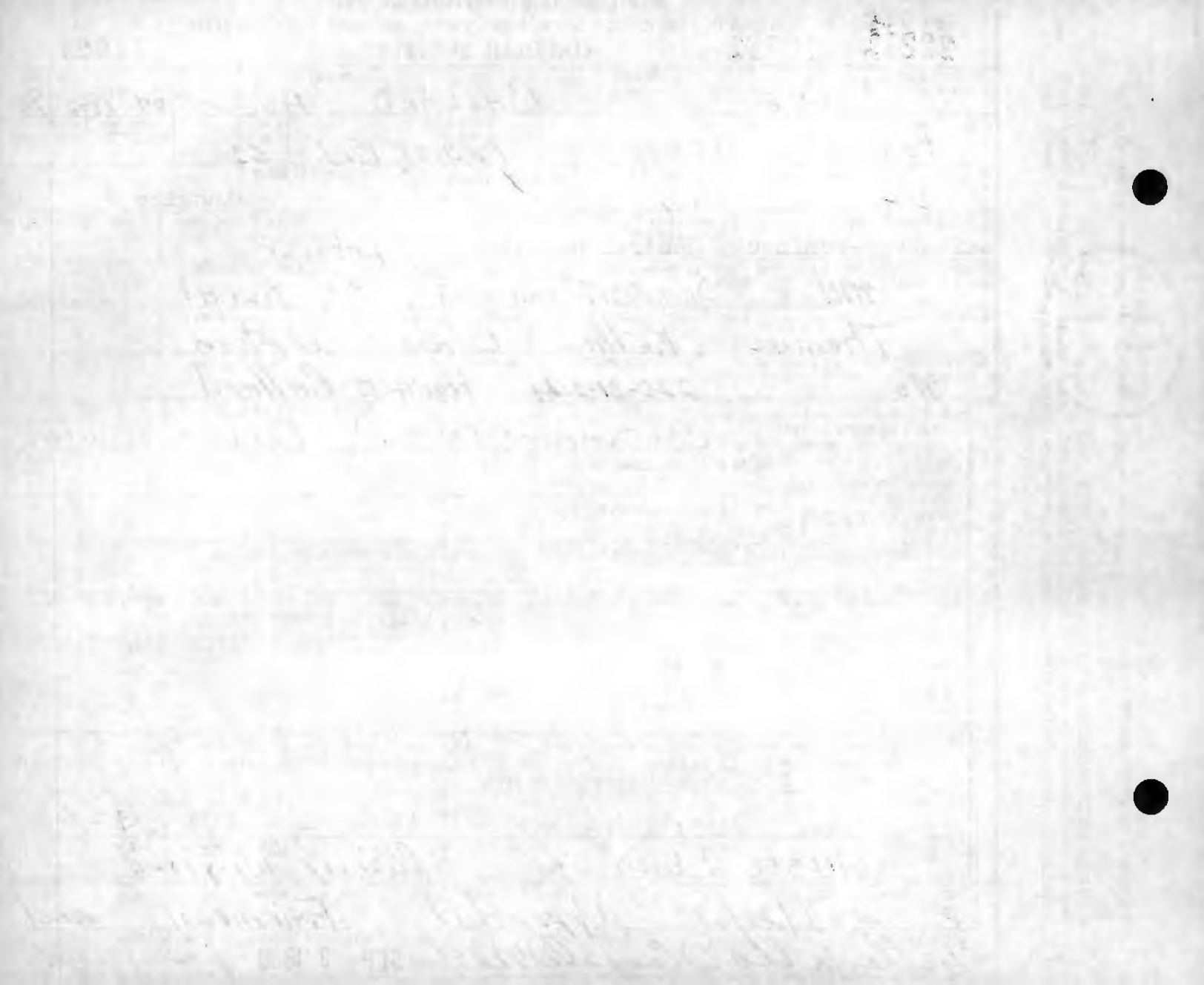


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VR A15 (10)  
30M REV. 1-68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
12211											
CERTIFICATE OF DEATH											
12221											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR	
LOUISE						BALLARD		AUGUST 24 1968		9 P.M.	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years lost birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
FEMALE		NEGRO		Feb. 28, 1917		52 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
VA.		U.S.				Wicomico		Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury-Peninsula		General Hospital		Laborer							
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Md		Somerset		Fairmount				RURAL			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Thomas		Kellam		Classie Watson							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No		220-01-3324		Horace Ballard							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Carcinomatous, unknown</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>primary</u> (c) <u>unknown</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>unknown</u>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>1992</u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>8-11</u> , 19 <u>68</u> to <u>8-24</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>8-24</u> , 19 <u>68</u> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE		22c. DATE SIGNED									
Wilbur R. Ellis, Jr.		8-24-68									
22d. PHYSICIAN'S NAME (Type)		22e. ADDRESS									
WILBUR R. ELLIS, JR.		Medical Center Salisbury, Maryland									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)	
Burial		8/28/68		Upper Hill		Fairmount		and			
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
Arthur E. Ward		Crisfield Md.		DATE SEP 3 1968		Charles Judge					



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove the coroner's papers, pages 1 and 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
- CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR
ELIZABETH		J.		BARTOSH		AUGUST		30		4:30 PM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER YEAR		IF UNDER 24 HRS.
FEMALE		White		May 2, 1924		44 YRS.		MONTHS DAYS		HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.		
Pennsylvania		USA				Wicomico				
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY				
Salisbury		Peninsula General Hospital		Housewife						
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Virginia		Fairfax		Vienna				8239 Winder Street		
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last
Albert		Zook						(unknown)		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address				
No		170-22-1551		Mr. Stephen L. Bartosh, Vienna, Virginia		8239 Winder St.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u>										<u>Unknown</u>
41 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. <u>42201</u>										
DUE TO, OR AS A CONSEQUENCE OF (b)										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
<u>Non-ventricular Fibrillation; Cerebral Embolism</u>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)						
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.		22b. SIGNATURE <u>David J. Gilmore</u>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED August 31, 1968				
22d. PHYSICIAN'S NAME (Type) Dr. David J. Gilmore		22e. ADDRESS Medical Center, Salisbury, Maryland								
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		Sept. 3, 1968		Calvary Memorial Park		Fairfax Virginia				
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
HOLLOWAY & COMPANY, SALISBURY, MARYLAND				SEP 4 1968		Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Page 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 -CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First JOSEPH		Middle OTTIS		Last Bozman		2a. DATE OF DEATH Month Day Year August 25 1968		2b. HOUR 18 M	
3. SEX MALE		4. RACE White		5. DATE OF BIRTH April 28, 1998		6. AGE (In years last birthday) 70 YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md.					
10. CITY OR TOWN OF DEATH Salisbury-Peninsula		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired.) Track Foreman		12b. KIND OF BUSINESS OR INDUSTRY Railroad					
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 201 Marshall Street			
14. FATHER'S NAME First Middle Last William Bozman		15. MOTHER'S M.A.D.N. NAME First Middle Last Sally Jane Heath									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO. A-971953		17. INFORMANT (Wife) Mrs. Stella M. Bozman, Salisbury, Maryland		Address 201 Marshall St.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>coronary thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>hypertensive cardiovascular disease</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>generalized arteriosclerosis</u> CONDITIONS, IF ANY, WHICH GAVE RISE TO IMMEDIATE CAUSE (a), STATING THE UNDERLYING CAUSE LAST PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 20 hrs yes yes	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 8/24, 1968, to 8/25, 1968, that (I) (we) last saw the deceased alive on 8/25, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE John S. Bulkeley		22c. DATE SIGNED 8/25/68		22d. PHYSICIAN'S NAME (Type) Dr. John T. Bulkeley		22e. ADDRESS S. Salisbury Blvd., Salisbury, Md.					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE August 28, 1968		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City or Town) (County) (State) Salisbury, Wicomico, Maryland					
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND		25a. REC'D BY REGISTRAR DATE AUG 28 1968		25b. REGISTRAR'S SIGNATURE Charles J. J...							





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
19214 CERTIFICATE OF DEATH 1968									
1. DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
RANDOLPH			STAPLES			BREWINGTON			Month Day Year 8 1 1968 11 A M
3 SEX		4. RACE		5. DATE OF BIRTH			6. AGE (In years lost birthday)		7. IF UNDER 1 YEAR MONTHS
Male		white		Jan. 15, 1885			83 YRS.		IF UNDER 24 HRS HOURS MIN
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Wicomico Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury			Peninsula General Hospital			Ret. Retail Sales		Nothing	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Wicomico		Salisbury		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		423 Pine Bluff Rd.,
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
William L. Brewington			Charlotte Virginia White						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No			088-10-1440		Mrs. Edith B. Ackley Sec 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Arteriosclerotic Heart Disease</i>									
4129 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: 4120									
DUE TO, OR AS A CONSEQUENCE OF (b)									
DUE TO, OR AS A CONSEQUENCE OF (c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (o)									
<i>Chronic Emphysema</i>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at home		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) last saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <i>David J. Gilmore M.D.</i>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 8-1-1968		
22d. PHYSICIAN'S NAME (Type) DAVID J. GILMORE					22e. ADDRESS SALISBURY, MARYLAND				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		8-3-1968		Parsons Cemetery		Salisbury, Maryland			
24. FUNERAL DIRECTOR ADDRESS Hill Funeral Home Salisbury, Maryland				25a. REC'D BY REGISTRAR DATE AUG 5 1968		25b. REGISTRAR'S SIGNATURE <i>J. Charles Judge</i>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
12215 CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
WALTON SCOTT BREWINGTON						Month Day Year			9:35 AM
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
Male		White		Nov. 11, 1897		70 YRS.		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Wicomico Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY
Salisbury			Peninsula General Hospital			Mechanic Garage			Owner
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER
Maryland			Wicomico		Salisbury		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		236 Ohio Ave.,
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
Henry Brewington			Annie Williams						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
NO			214-10-7590		Mrs. Verna Brewington, See Sec 13				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									
PART 1. DEATH WAS CAUSED BY:									
IMMEDIATE CAUSE (a) Myocardial Infarction									
DUE TO, OR AS A CONSEQUENCE OF									
(b) Atherosclerotic Coronary Artery Not Known									
DUE TO, OR AS A CONSEQUENCE OF									
(c) Disease									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
					YES <input type="checkbox"/> NO <input type="checkbox"/>				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year P.M. 19							
21d. INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION		City or Town		County State	
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>				Street or R.F.D. No.					
22a. I certify that (I) (this hospital) attended the deceased from 8/16/1968, to 8/16/1968, that (I) (we) last saw the deceased alive on 8/16/1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE				DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
Dr. O.J. Burton								8-16-1968	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
Dr. O.J. Burton				Salisbury, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County) (State)	
Burial		8/19/1968		Wicomico Memorial Park		Salisbury Wico.		MD.	
24. FUNERAL DIRECTOR ADDRESS				25a. REC'D BY REGISTRAR		25b. REGISTERED SIGNATURE			
Hill Funeral Home Salisbury, Maryland				DATE AUG 19 1968		John G. Jones			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

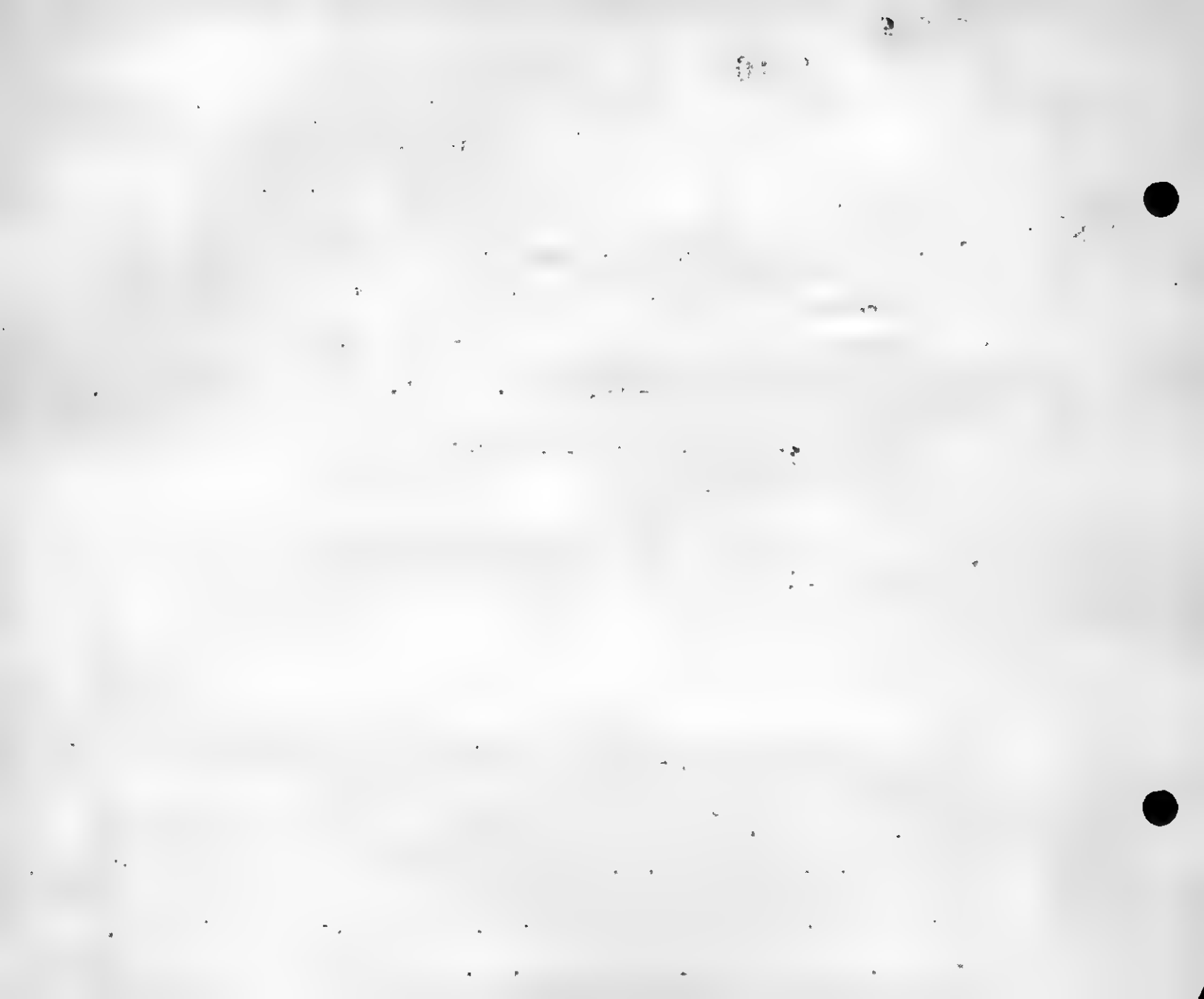
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# CERTIFICATE OF DEATH

12226

1. DECEASED NAME (Type or print) <b>Daniel Thomas Bridge</b>		2a. DATE OF DEATH 8 Month 26 Day 1968		2b. HOUR 6:35 A
3. SEX <b>Male</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>9/18/1904</b>		6. AGE (in years last birthday) <b>63</b> YRS
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Wicomico</b> Md	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Deer's Head State Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Farmer</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	13b. COUNTY <b>Talbot</b>	13c. CITY OR TOWN <b>Cordova</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER
14. FATHER'S NAME First Middle Last <b>Henry Bridge</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>Virginia Baynard</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown) <b>No</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO <b>219-34-4082</b>	17. INFORMANT Address <b>Mrs. Helen N. Bridge, RFD Cordova, Md.</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Massive pulmonary emboli</b> <b>450X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>0-48 hrs</b>				
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>465X CVA's - numerous</b>				
19a. DATE OF OPERATION	19b. CONDITION FOR WHICH OPERATION WAS PERFORMED	20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)	21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19	21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work	21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)	21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that (this hospital) attended the deceased from <b>June 24, 1968</b> , to <b>August 26, 1968</b> , that (we) lost saw the deceased alive on <b>August 26, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (he) (we) (did) (do) view the body after death.				
22b. SIGNATURE <i>A. C. Mitchell</i>		DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>	22c. DATE SIGNED <b>8/26/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>A. C. Mitchell, M. D.</b>		22e. ADDRESS <b>Deer's Head State Hospital; Salisbury, Md</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>burial</b>	23b. DATE <b>8/28/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>Concord Cemetery</b>	23d. LOCATION (City or Town) (County) (State) <b>Denton, Caroline, Md.</b>	
24. FUNERAL DIRECTOR ADDRESS <b>The Jay D. Heverin Funeral Home, Easton, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 29 1968</b>	REGISTRAR'S SIGNATURE <i>Charles Judge</i>	





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. Fill in pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MEDICAL CERTIFICATION

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print)		2a. DATE KNOWN OF DEATH				2b. HOUR		2c. DATE PRONOUNCED DEAD		2d. HOUR
Robert Norwood Brittingham		8/19/68		19		8		19		68
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE	7 UNDER 1 YEAR	7 UNDER 24 HRS					
male	white	4/29/1926	42 YRS	MONTHS	DAYS	HOURS	MIN			
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8. MARRIED		9. COUNTY OF DEATH						
Md.	U.S.	NEVER MARRIED		Wicomico						
10. CITY OR TOWN OF DEATH	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)	12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY						
Route 13 Near Eden Md.	Route 13	Trouble Service		Electric						
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE	13b COUNTY	13c CITY OR TOWN	13d. INSIDE CITY LIMITS?	13e. STREET AND NUMBER						
Md.	Somerset	Westover	YES <input type="checkbox"/> NO <input type="checkbox"/>							
14. FATHER'S NAME	15. MOTHER'S MAIDEN NAME									
Norwood Brittingham	Martha E. Dryden									
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)	16b SOCIAL SECURITY NO.	17. INFORMANT		ADDRESS						
yes		Mrs. Louise Brittingham,		Westover, Md.						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))										
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Compound fracture of skull</u>										
DUE TO, OR AS A CONSEQUENCE OF (b) <u></u>										
DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION										
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?										
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>										
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		9:00 P.M. 8/20/68		Automobile Accident						
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION (Street or R.F.D. No. City or Town County State)						
		Route 13 Near Eden Md.		Route 13 Eden Somerset Md.						
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE		M.D.		22b. DATE SIGNED						
EXAMINER'S NAME (Type)				8-20-68						
23a BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		8/22/68		Goodwill		Rural Pocomoke, Worcester, Md.				
24. FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE				
James Hannon		Princess Anne, Md.		AUG 26 1968		Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the registrar, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
12219 CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <i>Ellison</i> First Middle Last					2a. DATE OF DEATH <i>August 14</i> Month Day Year <i>1968</i>			2b. HOUR <i>6:40</i> AM		
3. SEX <i>FEMALE</i>		4. RACE <i>NEGRO</i>		5. DATE OF BIRTH <i>1922</i>			6. AGE (In years last birthday) <i>46</i> YRS.		IF UNDER - YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <i>Wicomico</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <i>Wicomico</i> Md.			
10. CITY OR TOWN OF DEATH <i>Salisbury-Peninsula</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>General Hospital</i>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Cornfields</i>			12b. KIND OF BUSINESS OR INDUSTRY <i>None</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution - Residence before admission) <i>Salisbury</i> STATE <i>MD</i>			13b. COUNTY <i>Wicomico</i>		13c. CITY OR TOWN <i>Salisbury</i>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <i>Road</i>	
14. FATHER'S NAME First Middle Last <i>Daniel Church</i>			15. MOTHER'S M.A.DEN NAME First Middle Last <i>Ella ?</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <i>No</i> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <i>---</i>		17. INFORMANT <i>Arnette Adkins</i> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>180X</i> <i>Uraemia</i> DUE TO, OR AS A CONSEQUENCE OF <i>Urterialobstruction</i> (b) <i>Ca Ex-stage IV</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Ca Ex-stage IV</i>									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>180X</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <i>8/11/68</i> , 19__, to <i>8/14/68</i> , 19__, that (I) (we) last saw the deceased alive on <i>8/13/68</i> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death										
22b. SIGNATURE <i>Stedman W. Smith</i>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <i>8/18/68</i>			
22d. PHYSICIAN'S NAME (Type)					22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <i>8-17-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Green Acres Cem</i>			23d. LOCATION (City or Town) (County) (State) <i>Salisbury Wicomico Md</i>			
24. FUNERAL DIRECTOR <i>Boaker M West</i> ADDRESS					25a. REC'D BY REGISTRAR <i>James J. Jones</i> DATE <i>AUG 23 1968</i>			25b. REGISTRAR'S SIGNATURE		

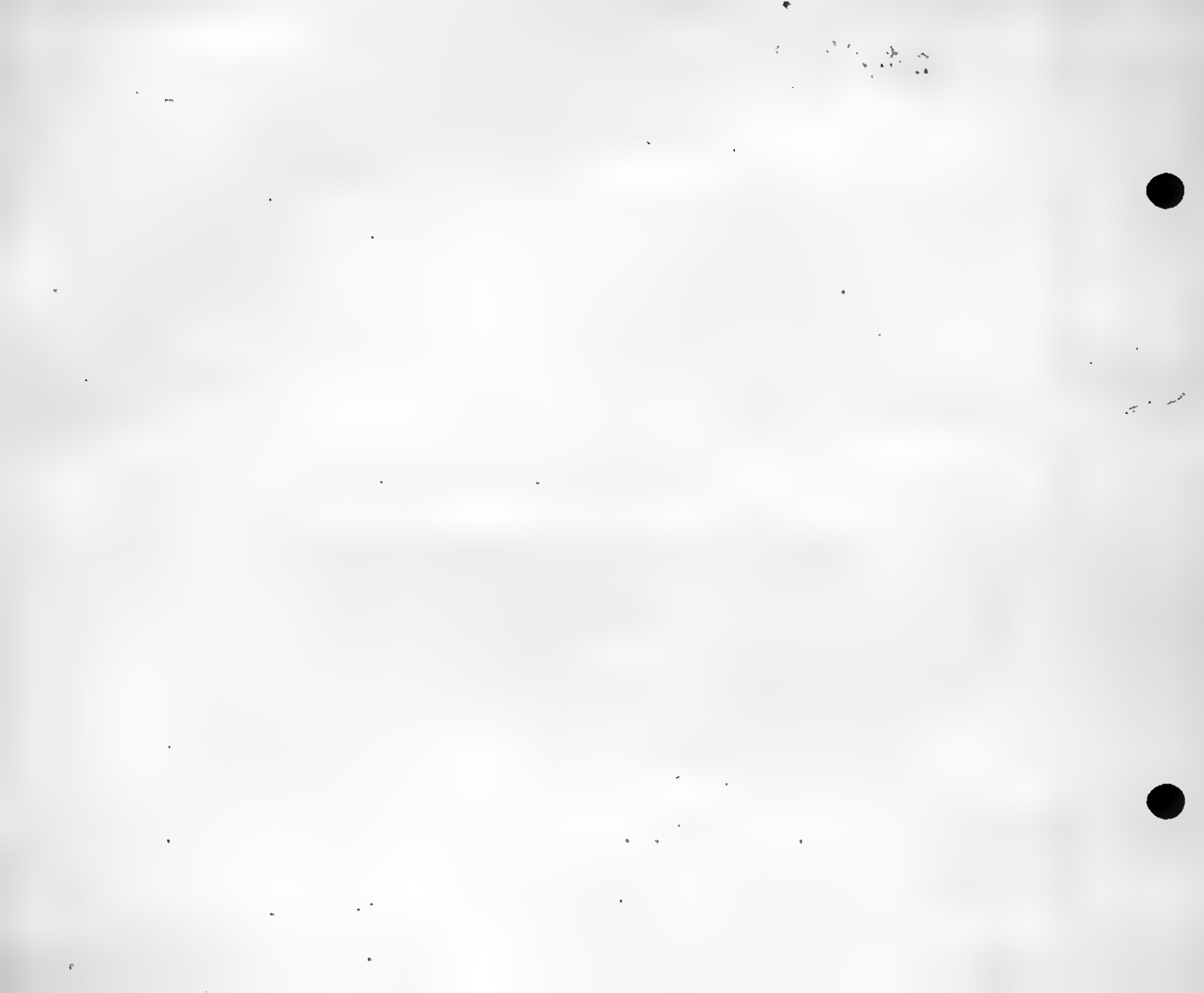


**FOR STATE  
HEALTH DEPT.**

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
MEDICAL EXAMINER'S CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or Print)			First SAMUEL		Middle JAMES		Last BROWN		2a. DATE KNOWN OF DEATH Month Day Year 8-1-68 19			2b. HOUR 1:15 P.M.
3 SEX M	4. RACE W	5. DATE OF BIRTH 6/28/1888		6 AGE (In years last birthday) 80 YRS	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD Month Day Year 8 1 1968		2d. HOUR 1:45 P.M.	
7a. BIRTHPLACE (State or foreign country) Ireland		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Wicomico Md						
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) 310 Poplar Hill Ave.			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Ret-Cyanamide Co.			12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, first full on. Residence before admission) STATE Md.			13b. COUNTY Wicomico			13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER 310 Poplar Hill Ave.		
14. FATHER'S NAME First Middle Last James Brown			15. MOTHER'S MAIDEN NAME First Middle Last Florence (unknown)									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) No			16b. SOCIAL SECURITY NO (If yes give war or dates of service)			17. INFORMANT Mrs Florence B Metz - Harlock ADDRESS						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Coronary occlusion DUE TO, OR AS A CONSEQUENCE OF (b) Arteriosclerotic cardio-vascular disease years DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH sudden												
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)												
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No		City or Town		County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE Earl L. Royer, M.D.			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			22b. DATE SIGNED Aug. 5, 1968
EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md			ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 8/4/68		23c. NAME OF CEMETERY OR CREMATORY East New Market		23d. LOCATION (City or Town) East New Market, Md		(County)		(State)		
24. FUNERAL DIRECTOR Willoughby Funeral Home, East New Market			ADDRESS			25a. REC'D BY REGISTRAR DATE Md. AUG 8 1968		25b. REGISTRAR'S SIGNATURE Charles J. J...				





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
12220 - CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First JAMES		Middle AGUSTUS		Last Burroughs		2a. DATE OF DEATH Month Day Year August 9 68		2b. HOUR 5:30 P.M.	
3. SEX Male		4. RACE White		5. DATE OF BIRTH 4/24/1906		6. AGE (In years last birthday) 62 YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Virginia		7b. CITIZEN OF WHAT COUNTRY? USA		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico		Md.			
10. CITY OR TOWN OF DEATH Salisbury-Peninsula				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Lino-type Operator		12b. KIND OF BUSINESS OR INDUSTRY Newspaper			
13a. USUAL RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE Virginia				13b. COUNTY Northampton		13c. CITY OR TOWN Cape Charles		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER ---	
14. FATHER'S NAME First Middle Last John Henry Burroughs				15. MOTHER'S MAIDEN NAME First Middle Last Laura Moore							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No		(If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT (Daughter) Address Mrs. Nancy B. Purnell, Berlin, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Congestive Failure - cor pulmonale 4 months DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost: 4 months (b) Emphysema + chronic bronchitis Not known DUE TO, OR AS A CONSEQUENCE OF (c) Cigarette Smoking. Not known										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (c). Arteriosclerotic heart disease. Atrial fibrillation											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 8/6/1968, to 8/9/1968, that (I) (we) last saw the deceased alive on 8/8/1968, and that in (my/our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE DR. D. J. Burton				DEGREE ATTENDING PHYS.		<input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED August 9, 1968			
22d. PHYSICIAN'S NAME (Type) DR. D. J. Burton				22e. ADDRESS Medical Center, Salisbury, Maryland							
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE 8/12/68		23c. NAME OF CEMETERY OR CREMATORY Capeville Cemetery		23d. LOCATION (City or Town) Capeville, Northampton, Va.		(County)		(State)	
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND				ADDRESS		25a. RECD. BY REGISTRAR DATE AUG 12 1968		25b. REGISTRAR'S SIGNATURE John J. Judge			

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12221 12221 12231											
1. DECEASED-NAME (Type or print) <b>Theresa M. Carr</b>				2a. DATE OF DEATH Month <b>August</b> Day <b>14</b> Year <b>1968</b>		2b. HOUR <b>4:58</b> M <b>M</b>					
3 SEX <b>Female</b>		4 RACE <b>Negro</b>		5. DATE OF BIRTH <b>12/I/1896</b>		6 AGE (In years last birthday) <b>71</b> YRS		7 IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		8 IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>	
7a. BIRTHPLACE (State or foreign country) <b>Princess Anne</b>			7b. CITIZEN OF WHAT COUNTRY? <b>U S A</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Wicomico</b> Md		
10. CITY OR TOWN OF DEATH <b>Salisbury-Peninsula General Hospital</b>				11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <b>House wife</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>House work</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b> COUNTY <b>Somerset</b>				13b. CITY OR TOWN <b>Princess Anne</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>----</b>			
14. FATHER'S NAME First <b>Saul</b> Middle <b>Roberts</b> Last <b>Roberts</b>				15. MOTHER'S MAIDEN NAME First <b>Leah</b> Middle <b>Dennis</b> Last <b>Dennis</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown				16b. SOCIAL SECURITY NO.		17 INFORMANT Address <b>Leon Carr.Princess Anne,Md</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>renal failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>chronic pyelonephritis</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diabetes Mellitus - Pneumonia</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>5 days</b> <b>yks</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <b>Aug 14, 1968</b> , to <b>Aug 14, 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug 14, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b. SIGNATURE <b>John Wesley</b>				DEGREE <b>PHYS</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>8/17/68</b>			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8/18/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>John Wesley</b>		23d. LOCATION (City or Town) (County) (State) <b>Princess Anne, Md</b>					
24. FUNERAL DIRECTOR <b>William H James Jr.Princess Anne,Md</b>				25a. REC'D BY REGISTRAR <b>DATE AUG 21 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
304 REV

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**12822**  
**CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or print) <b>MARGARET E. Collick</b>			2a. DATE OF DEATH Month <b>August</b> Day <b>20</b> Year <b>1968</b>			2b. HOUR <b>5<sup>30</sup> P M</b>				
3 SEX <b>Female</b>		4. RACE <b>Negro</b>		5. DATE OF BIRTH <b>3-20-1886</b>		6. AGE (In years last birthday) <b>82</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <b>Synpuxent</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		B. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b>				
10. CITY OR TOWN OF DEATH <b>Salisbury-Peninsula General Hospital</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>MARYLAND</b>			13b. COUNTY <b>Worcester</b>		13c. CITY OR TOWN <b>Beelin</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>R.F.D.#3 Box 210</b>	
14. FATHER'S NAME First Middle Last <b>Milby Dickerson</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>MARGARET Johnson</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH CAUSED BY <b>42.9</b> IMMEDIATE CAUSE (a) <b>Cerebral thromboses</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>12 days</b>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (this hospital) attended the deceased from <b>8-20</b> , 19 <b>68</b> , to <b>8-20</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8-20</b> , 19 <b>68</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>William R. Collick</b>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED-DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>8-23-68</b>				
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS						
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
<b>BURIAL</b>		<b>8-24-68</b>		<b>DAVIS</b>		<b>SYNPUXENT WORC-Md.</b>				
24. FUNERAL DIRECTOR <b>Loretta B. Colley</b>				ADDRESS <b>Jerry R. #2 Salisbury</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 5 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>		

MEDICAL CERTIFICATION





should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. DECEASED-NAME (Type or print)		First IDA		Middle JANE		Last FRANCES		Last COOK		2a. DATE OF DEATH Month August		Day 15		Year 1968		2b. HOUR 6:15		P. P.			
3 SEX Female		4. RACE Negro				5. DATE OF BIRTH Nov. 27, 1881				6. AGE (In years last birthday) 86 YRS		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS DAYS		IF UNDER 24 HRS HOURS		IF UNDER 24 HRS MIN.			
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA				8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH Wicomico													
10. CITY OR TOWN OF DEATH Mardela Springs, RFD				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) San Domingo				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Housework				12b. KIND OF BUSINESS OR INDUSTRY Home									
13a. USUAL RESIDENCE (Where deceased lived, if not in hospital admission) Maryland				13b. COUNTY Wicomico				13c. CITY OR TOWN Mardela Springs				13d. INSIDE CITY LIM. 15? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER R.F.D. #1, Box 119 C							
14. FATHER'S NAME First William L. Brown						15. MOTHER'S MAIDEN NAME First Rachel A. Gaines															
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, pg. or unknown) <input type="checkbox"/> No <input checked="" type="checkbox"/> (If yes, )				16b. SOCIAL SECURITY NO. 215-48-6927				17 INFORMANT Address Martena M. Gaines, Mardela Springs, Md., RFD													
18. CAUSE OF DEATH (Enter only one cause per line, for (a), (b), and (c))																					
PART 1. DEATH WAS CAUSED BY																					
IMMEDIATE CAUSE (a) <u>General Arterio Sclerosis</u>																					
DUE TO, OR AS A CONSEQUENCE OF																					
(b) <u>Colitis</u>																					
DUE TO, OR AS A CONSEQUENCE OF																					
(c)																					
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																					
4																					
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?									
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)													
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)				21f. LOCATION Street or R.F.D. No. City or Town County State													
22a. I certify that (I) (this hospital) attended the deceased from <u>Aug 13</u> , 1968, to <u>Aug 14</u> , 1968, that (I) (we) lost saw the deceased alive on <u>Aug 13</u> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.																					
22b. SIGNATURE <u>H. S. Kupelman</u> DEGREE ATTENDING <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF <input type="checkbox"/> 22c. DATE SIGNED <u>8/16/68</u>																					
22d. PHYSICIAN'S NAME (Type) <u>H. S. Kupelman</u> 22e. ADDRESS <u>Sharptown Md</u>																					
23a. BURIAL, CREMATION, REMOVING (Specify)				23b. DATE Aug. 18, 1968				23c. NAME OF CEMETERY OR CREMATORY Zion Church Cemetery				23d. LOCATION (City or Town) (County) (State) Near Sharptown, Maryland									
24. FUNERAL DIRECTOR <u>J. J. Frampton and Son, Federalsburg, Maryland</u> ADDRESS 25a. REC'D BY REGISTRAR <u>AUG 23 1968</u> 25b. REGISTRAR'S SIGNATURE <u>J. Charles Jones</u>																					

2000



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please give carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
304A REV. 1-58

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
12224 CERTIFICATE OF DEATH 12234											
1 DECEASED-NAME (Type or print) First Middle Last <b>MARY FRANCES COOPER</b>						2a. DATE OF DEATH Month Day Year <b>August 10 1968</b>			2b. HOUR <b>1:40 P M</b>		
3. SEX <b>Female</b>		4 RACE <b>Colored</b>		5. DATE OF BIRTH <b>9/21/92</b>			6. AGE (In years last birthday) <b>75</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>WICOMICO</b>			Md.	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Deer's Head State Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) - STATE <b>Maryland</b>				13b. COUNTY <b>Talbot</b>		13c. CITY OR TOWN <b>Easton</b>		3d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Rt. #4, Box 136</b>	
14. FATHER'S NAME First Middle Last <b>Tom Cooper</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Margaret Johns</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give year or dates of service) <b>No</b>				16b. SOCIAL SECURITY NO <b>220 03 8979</b>		17. INFORMANT Address <b>Rosetta Smith, RFD #4, Box 150, Easton</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Bronchopneumonia, Right Lung</b> <b>483X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>7/21/92</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>3 days</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Cerebral Thrombosis and Diabetes Mellitus</b>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (X) (this hospital) attended the deceased from <b>June 10</b> , 19 <b>68</b> , to <b>August 10</b> 19 <b>68</b> , that (X) (we) last saw the deceased alive on <b>August 10</b> , 19 <b>68</b> , and that in (X) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (not) view the body after death											
22b. SIGNATURE <b>L. V. Maldve</b>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>8/12/68</b>			
22d. PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>						22e. ADDRESS <b>Deer's Head State Hospital, Salisbury, Md</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8/13/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Williamsburg</b>				23d. LOCATION (City or town) (County) (State) <b>Talbot, Maryland</b>			
24. FUNERAL DIRECTOR <b>Barbara L. Dashiell</b>						25a. REC'D BY REGISTRAR <b>426 Dover St. Easton</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			
DATE <b>AUG 16 1968</b>											



12225

CERTIFICATE OF DEATH

12230

1. DECEASED NAME (Type or print) <b>JOHN CORBIN</b>			2a. DATE OF DEATH Month <b>August</b> Day <b>3</b> Year <b>1968</b>			2b. HOUR <b>7:05 PM</b>	
3. SEX <b>Male</b>		4. RACE <b>Colored</b>		5. DATE OF BIRTH <b>June 10, 1924</b>		6. AGE (In years last birthday) <b>44</b> YRS.	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>WICOMICO</b> Md.	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Deer's Head State Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Labor</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. U.S.A. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Salisbury</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
13e. STREET AND NUMBER <b>1007 Delaware Avenue</b>		14. FATHER'S NAME First <b>James</b> Middle <b>Corbin</b> Last <b>Corbin</b>		15. MOTHER'S MAIDEN NAME First <b>Rosa</b> Middle <b>Johnson</b> Last <b>Johnson</b>		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b> (If yes give war or dates of service)	
16b. SOCIAL SECURITY NO.		17. INFORMANT <b>James Corbine</b>		Address <b>604 Wicomico St.</b>		City <b>Salisbury</b> Md.	

18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic carcinoma of pancreas</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Carcinoma of stomach.</b> DUE TO, OR AS A CONSEQUENCE OF (c)		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>9 months</b> <b>1 year</b>
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PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)

**Obstructive jaundice**

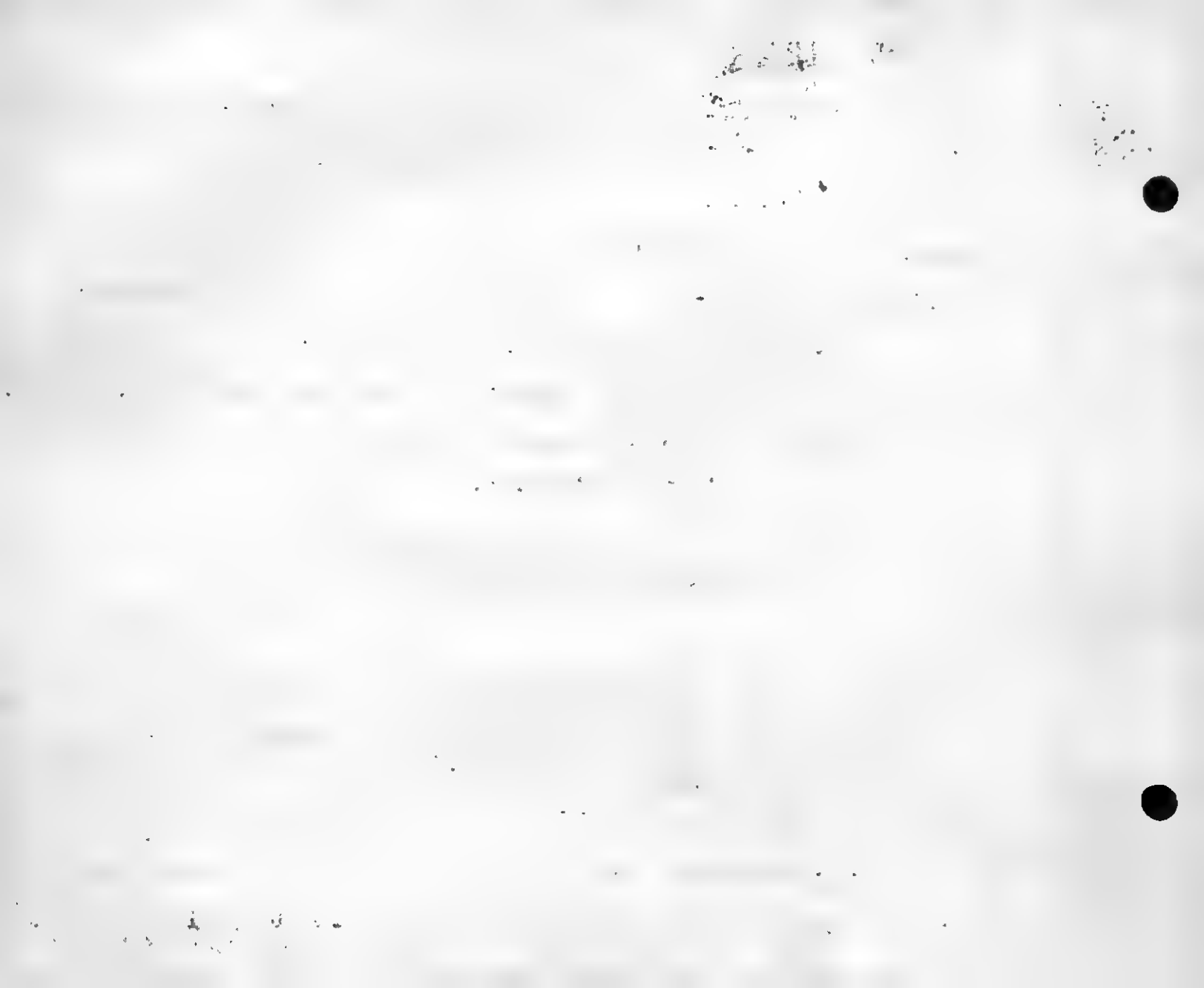
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (1) (this hospital) attended the deceased from <b>July 15</b> , 19 <b>68</b> , to <b>August 3</b> , 19 <b>68</b> , that (1) (we) lost the deceased alive on <b>August 3</b> , 19 <b>68</b> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (1) (we) (did) (not) view the body after death.							

22b. SIGNATURE <i>C. N. Winnacott</i>		DEGREE <b>MD.</b>		ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED <b>8/5/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>C. N. Winnacott, M. D.</b>		22e. ADDRESS <b>Deer's Head State Hospital, Salisbury,</b>		City <b>Salisbury</b>		State <b>Maryland</b>	

23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8/8/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Green Acres</b>		23d. LOCATION (City or Town) (County) (State) <b>Salisbury Wicomico Md.</b>	
24. FUNERAL DIRECTOR <i>Clinton F. Stewart</i>		ADDRESS <b>Salisbury Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 12 1968</b>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (Pages 1 and 2) and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12226 CERTIFICATE OF DEATH											
1 DECEASED NAME (Type or print) First Middle Last Fenton William DAVIS		2a DATE OF DEATH Month Day Year August 31 1968			2b HOUR 9:50 AM						
3 SEX MALE		4 RACE White		5 DATE OF BIRTH Aug. 10, 1906		6 AGE (In years last birthday) 68 YRS.		7 UNDER 1 YEAR MONTHS DAYS		8 UNDER 24 HRS HOURS MIN.	
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md					
10 CITY OR TOWN OF DEATH Salisbury		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Shirt Factory			12b KIND OF BUSINESS OR INDUSTRY Shirt		
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE Md.		13b. COUNTY Wicomico		13c CITY OR TOWN Powellville		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER Powellville-Snow Hill Rd			
14. FATHER'S NAME First Middle Last Winfred Davis		15 MOTHER'S MAIDEN NAME First Middle Last Grace Timmons									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes (no, or unknown) No		16b. SOCIAL SECURITY NO		17 INFORMANT Mrs. Esther Truitt Address Pittsville, Md							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebral Arteriosclerosis 4339 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) with thrombosis DUE TO, OR AS A CONSEQUENCE OF (c)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH Unknown	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 333 Marked malnutrition											
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING ETC		21f. LOCATION Street or RFD No City or Town County State							
22a I certify that (I) (this hospital) attended the deceased from 8-29, 1968, to 8-31, 1968, that (I) (we) last saw the deceased alive on 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b SIGNATURE David J. Gilmore DEGREE						ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED			
22d PHYSICIAN'S NAME (Type) David J. Gilmore						22e ADDRESS					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE 9-2-1968		23c NAME OF CEMETERY OR CREMATORY St. Johns Cemetery		23d LOCATION (City or Town) (County) (State) Powellville Wico. Md.					
24 FUNERAL DIRECTOR Thomas F. Wallace Salisbury, Md.						25a REC'D BY REGISTRAR DATE SEP 3 1968		25b. REGISTRAR'S SIGNATURE Charles Judge			

134

134



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
<div style="text-align: center;"> <b>12227</b>  <b>CERTIFICATE OF DEATH</b> </div>									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b. HOUR
Carrie WOOTTEN			Dennis			August 1, 1968			8:45 AM
3. SEX	4. RACE		5. DATE OF BIRTH			6. AGE (in years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female	White		August 7, 1879			88 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Delaware		USA				Wicomico Md.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital have street address)			12a. USJA: OCCUPATION (Kind of work done during part of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury - Peninsula General Hospital			Housewife			none			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER
Maryland			Wicomico		Mardela				Bridge Street
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME						
James S. Donaway			Louisa Andrews						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT (Son) Address				
No			220-28-4761		Mr. George D. Dennis, Mardela, Maryland				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Artery Thrombosis</u> 4109 DUE TO, OR AS A CONSEQUENCE OF (b) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (c) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE FATAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 4									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No.		City or Town		County State	
22a. I certify that (I) (the hospital) attended the deceased from _____, 19____, to _____, 19____, that (I) (we) lost saw the deceased alive on _____, 19____, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (d.d.) (did not) view the body after death									
22b. SIGNATURE <u>David J. Gilmore</u>					22c. DATE SIGNED August 1, 1968				
22d. PHYSICIAN'S NAME (Type) David J. Gilmore					22e. ADDRESS Medical Center, Salisbury, Md				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		August 3, 1968		Parsons Cemetery		Salisbury, Wicomico, Maryland			
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND					25a. REC'D BY REGISTRAR AUG 5 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completed and filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
12223											
CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print) <b>RHONA MAE ELLIS</b>						2a. DATE OF DEATH Month <b>AUGUST</b> Day <b>21</b> Year <b>1968</b>			2b. HOUR <b>4 P M</b>		
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>Sept-13-1885</b>		6. AGE (In years last birthday) <b>82</b> YRS		7. UNDER 1 YEAR MONTHS <b></b> DAYS <b></b>		8. UNDER 24 HRS. HOURS <b></b> MIN <b></b>	
7a. BIRTHPLACE (State or foreign country) <b>Virginia</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b> Md.					
10. CITY OR TOWN OF DEATH <b>Salisbury-Peninsula General Hospital</b>				11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Salisbury-Peninsula General Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>None</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>Del.</b>				13b. COUNTY <b>Accomack</b>		13c. CITY OR TOWN <b>Salix</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Salix</b>	
14. FATHER'S NAME First <b>Thomas</b> Middle <b>Evans</b> Last <b></b>				15. MOTHER'S MAIDEN NAME First <b>Rellie</b> Middle <b>Linton</b> Last <b></b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>				16b. SOCIAL SECURITY NO <b>229-07-0264</b>		17. INFORMANT Address <b>Mrs Mary Linton - Salix, Del.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											
PART 1. DEATH CAUSED BY IMMEDIATE CAUSE (a) <b>arterio-sclerotic heart disease</b>											
4121 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
(b) DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
MEDICAL CERTIFICATION											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)				21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work				21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.				21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>8-14</b> , <b>1968</b> , to <b>8-21</b> , <b>1968</b> , that (I) (we) last saw the deceased alive on <b>8-21</b> , <b>1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>William B. Ellis</b>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>8-23-68</b>			
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS					
23a. BURIAL CREMATION, REMOVAL (Specify)				23b. DATE <b>7/23/69</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Ellis Ceme</b>		23d. LOCATION (City or Town) (County) (State) <b>Salix, Accomack Va.</b>			
24. FUNERAL DIRECTOR <b>James H. Fox Temperanceville, Va.</b>						25a. REC'D BY REGISTRAR DATE <b>AUG 27 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>			



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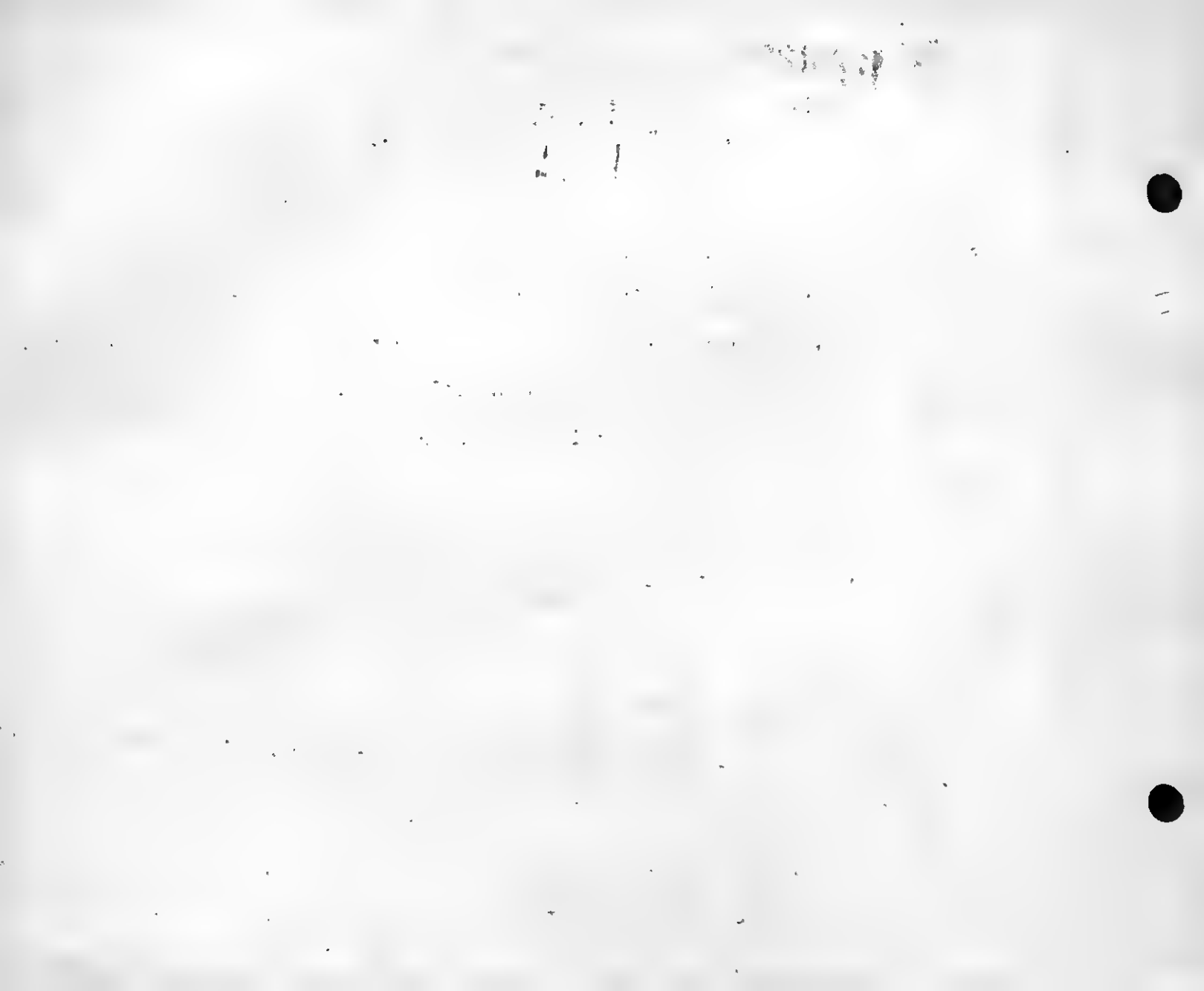
MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12225 CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print) First Middle Last WALTER HUMPHREY FARLOW						2a. DATE OF DEATH Month Day Year August 7 1968		2b. HOUR 6:55 PM		
3. SEX Male		4 RACE White		5 DATE OF BIRTH June 29, 1891		6 AGE (In years lost birthday) 77 YRS		F UNDER 1 YEAR MONTHS DAYS		
7a BIRTHPLACE (State or foreign country) Maryland		7b CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH WICOMICO Md.				
10. CITY OR TOWN OF DEATH Salisbury			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Retired - Hatcheryman		12b KIND OF BUSINESS OR INDUSTRY		
13a USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE Maryland			13b. COUNTY Wicomico		13c. CITY OR TOWN Pittsville		13d. NSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER ---	
14 FATHER'S NAME First Middle Last Humphrey Theodore Farlow				15 MOTHER'S MAIDEN NAME First Middle Last Annie Jarman						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) No			16b SOCIAL SECURITY NO. (If yes give year or dates of service) 214-34-7443		17 INFORMANT (Wife) Mrs. N. Ruth Farlow, Pittsville, Maryland				Address	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>generalized cancer metastases</u> DUE TO, OR AS A CONSEQUENCE OF <u>carcinoma of the breast</u> (b) <u>carcinoma of the breast</u> DUE TO, OR AS A CONSEQUENCE OF (c) Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1 yr. 4 yrs.	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) 120X										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from 8/7/68 to 8/7/68, that (I) (we) lost the deceased alive on 8/7/68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <u>Dr. E. M. Beardsley</u>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED August 7 1968		
22d. PHYSICIAN'S NAME (Type) Dr. E. M. Beardsley						22e. ADDRESS 211 Maryland Avenue, Salisbury, Md.				
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE August 10, 1968		23c. NAME OF CEMETERY OR CREMATORY Pittsville Cemetery		23d. LOCATION (City or Town) (County) (State) Pittsville, Wicomico, Maryland				
24 FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND						25a. REC'D BY REGISTRAR DATE AUG 12 1968		25b. REGISTRAR'S SIGNATURE <u>[Signature]</u>		



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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.  
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MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**12230**  
**CERTIFICATE OF DEATH**

1. DECEASED NAME (Type or print) First Middle Last <b>Barbara Margaret Field</b>			2a. DATE OF DEATH Month Day Year <b>August 9 1968</b>		2b. HOUR <b>2 P.M.</b>
3. SEX <b>Female</b>	4. RACE <b>White</b>	5. DATE OF BIRTH <b>June 6, 1875</b>		6. AGE (in years last birthday) <b>93</b> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <b>Missouri</b>	7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Wicomico</b> Md.		
10. CITY OR TOWN OF DEATH <b>Salisbury</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Springhill Sanitarium Inc.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Delaware</b>	13b. COUNTY <b>New Castle</b>	13c. CITY OR TOWN <b>Newark</b>	13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>R. F. D. # 2</b>	
14. FATHER'S NAME First Middle Last <b>Julius Christian Feldman</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Johanna Lauterbach</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO. <b>yes</b>	17. INFORMANT Address <b>J. C. Field R. F. D. # 5 Salisbury, Md.</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Crebral thrombosis</b> <b>433.9</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>--</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>-</b> APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 day</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>previous - crebral thrombosis</b>					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner) 21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b> 21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) 21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>May 19 68</b> to <b>8/9 1968</b> , that (I) (we) last saw the deceased alive on <b>8/5 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b. SIGNATURE <b>E. M. Beardsley MD</b>		DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>8/9/68</b>	
22d. PHYSICIAN'S NAME (Type) <b>E. M. Beardsley</b>		22e. ADDRESS <b>Salisbury, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>	23b. DATE <b>8/12/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>ChesterxxxxxM Cem.</b>		23d. LOCATION (City or Town) (County) (State) <b>Chestertown, Md.</b>	
24. FUNERAL DIRECTOR <b>W. Willis Wells</b>		ADDRESS <b>Chestertown, Md.</b>		25a. REC'D BY REGISTRAR <b>AUG 14 1968</b>	25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>





# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## 12231 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

**FOR STATE HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PH-3. If page 5 may be retained for your files.  
 TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

1. DECEASED-NAME (Type or Print)		First	Middle	Last	2a. DATE KNOWN OF DEATH		Month	Day	Year	2b. HOUR
JOSEPH BERNARD FIELDS					ESTIMATED <input type="checkbox"/> MATED <input type="checkbox"/>		8	26	1968	M
3 SEX	4 RACE	5. DATE OF BIRTH		6 AGE (In years last birthday)	7. UNDER 1 YEAR		8. UNDER 24 HRS		2c. DATE PRONOUNCED DEAD	
Male	White	October 19, 1881		86 YRS	MONTHS DAYS		HOURS MIN		Month	Day
									August	26
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		2d. HOUR		
Maryland		USA				WICOMICO		M		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury		Peninsula General Hospital				Laborer		Care-taker		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER		
Maryland		Wicomico		Salisbury		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		R.D.#1		
14. FATHER'S NAME				15. MOTHER'S MAIDEN NAME						
George Handy Fields				Annie Washburn						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT (Son)				ADDRESS R.D.#1		
No		213-16-8900		Mr. William L. Fields, Salisbury, Maryland						
18. CAUSE OF DEATH (Enter on one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Crowning Occlusion</u>										<u>Sudden</u>
4109 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last										<u>year</u>
(b) <u>ASCVD</u>										
DUE TO, OR AS A CONSEQUENCE OF										
(c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
4201										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
								YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
		HOUR A.M. P.M. 19								
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural cause <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED		
EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.				ASS STANT MEDICAL EXAMINER <input type="checkbox"/>				August 29 / 1968		
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)		
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)
Burial		August 29, 1968		Shad Point Cemetery		Salisbury, Wicomico, Maryland				
24. FUNERAL DIRECTOR				ADDRESS				25a. REGISTRY		
HOLLOWAY & COMPANY, SALISBURY, MARYLAND								AUG 30 1968		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
12232 CERTIFICATE OF DEATH									
1. DECEASED-NAME (Type or print) <b>GROVER</b> <b>BACHE</b> <b>GILL</b>			2a. DATE OF DEATH Month <b>AUGUST</b> Day <b>10</b> Year <b>1968</b>			2b. HOUR <b>4:10 PM</b>			
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>JAN. 22, 1890</b>		6. AGE (in years last birthday) <b>78</b> YRS.		7. UNDER 1 YEAR MONTHS DAYS	
7a. BIRTHPLACE (State or foreign country) <b>VIRGINIA</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b> Md.			
10. CITY OR TOWN OF DEATH <b>Salisbury-Peninsula General Hospital</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>PHYSICIAN</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>MARYLAND</b> COUNTY <b>MONTGOMERY</b>		13b. CITY OR TOWN <b>CHEVY CHASE</b>		13c. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>5800 DEAL PLACE</b>			
14. FATHER'S NAME First <b>THOMAS H.</b> Middle <b>GILL</b> Last			15. MOTHER'S MAIDEN NAME First <b>VICTORIA</b> Middle <b>FRENCH</b> Last						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no or unknown <b>YES</b> (If yes give year or dates of service) <b>W.W.I.</b>		16b. SOCIAL SECURITY NO. <b>217-42-0070</b>		17. INFORMANT <b>MRS. ONDA P. GILL, WIFE, SAME AS #13</b>		Address			
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Arteriosclerotic Heart Disease</b> <b>4129</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>15 yr</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>8-8</b> , 19 <b>68</b> , to <b>8-10</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>8-10</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the cause(s) stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <b>David J. Gilmore</b>		DEGREE		ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>8-10-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>David J. Gilmore</b>		22e. ADDRESS <b>Medical Center Salisbury, Maryland 21801</b>							
23a. BURIAL CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8-13-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Washington, D.C.</b>			
24. FUNERAL DIRECTOR <b>Joseph Gawler's Sons, Inc., N.W., Wash., D.C., 20016</b>				ADDRESS <b>5130 Wisc. Ave.</b>		25a. REC'D BY REGISTRAR <b>AUG 13 1968</b>		25b. REGISTERED SIGNATURE <b>John J. [Signature]</b>	



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## 12233 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

12243

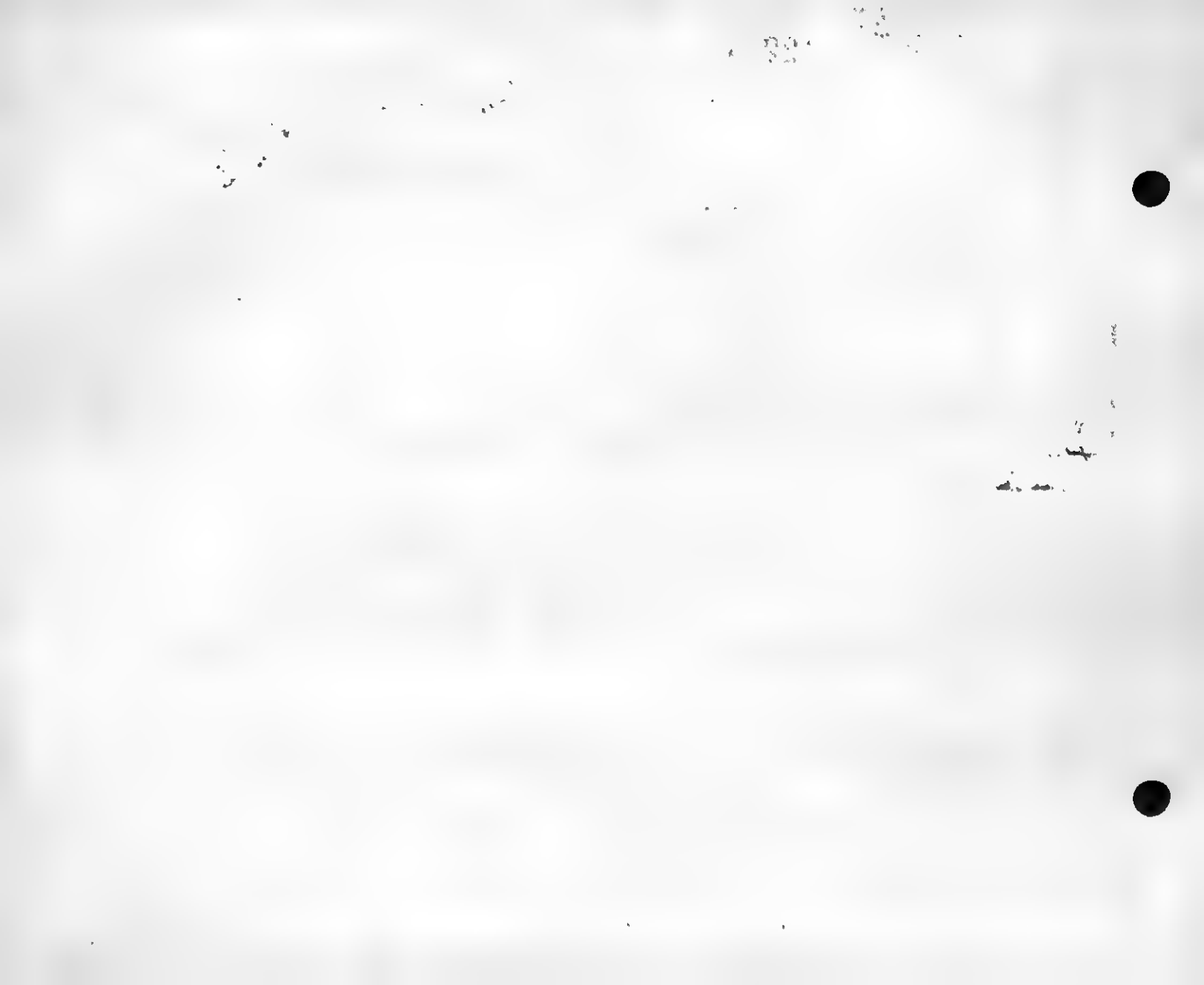
1 DECEASED NAME (Type or Print) <u>Thomas</u>		2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <u>Aug</u> Day <u>21</u> Year <u>1968</u>		2b HOUR <u>M</u>
3 SEX <u>Male</u>	4 RACE <u>Negro</u>	5 DATE OF BIRTH <u>Dec. 25/1893</u>	6 AGE (n years past birthday) <u>74</u> YRS	7c DATE PRONOUNCED DEAD Month <u>Aug</u> Day <u>21</u> Year <u>1968</u>
7a BIRTHPLACE (State or foreign country) <u>Fla.</u>	7b CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH <u>Wicomico</u>	
10 CITY OR TOWN OF DEATH <u>Salisbury</u>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <u>Pen. Gen. Hosp.</u>	12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <u>Laborer</u>	12b KIND OF BUSINESS OR INDUSTRY <u>Farm</u>	
13a USUAL RESIDENCE (Where deceased lived, if not put on Residence before admission) STATE <u>Md.</u>	13b COUNTY <u>Worcester</u>	13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e STREET AND NUMBER <u>Rt. 3 Bx. 37</u>	
14 FATHER'S NAME First <u>James</u> Middle <u>Davis</u> Last <u>Mary</u>	15 MOTHER'S MAIDEN NAME First <u>Mary</u> Middle <u>Williams</u> Last <u>Williams</u>		16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>	
16b SOCIAL SECURITY NO <u>264-03-6860</u>		17 INFORMANT <u>Gracie Bradshaw</u>		17 ADDRESS <u>Rt. 3 Bx. 293 Ocala, Fla.</u>
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>Generalized Atherosclerosis</u> (b) <u>Generalized Atherosclerosis</u> DUE TO, OR AS A CONSEQUENCE OF (c) _____				APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>201</u>				
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>	21b TIME OF INJURY Month, Day, Year <u>Aug 19 19</u>	21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>	21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)	21f LOCATION Street or R.F.D. No	City or Town	County State
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>				
ACTUAL SIGNATURE <u>James G. Dwyer</u> M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b DATE SIGNED <u>8-23-68</u>
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		
		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		
		ADDRESS (Street, city, town, or county)		
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE <u>8-26-68</u>	23c NAME OF CEMETERY OR CREMATORY <u>Wharton Mem. Cem.</u>	23d LOCATION (City or Town) <u>Parksley</u>	(County) <u>Accomack</u> (State) <u>Va.</u>
24 FUNERAL DIRECTOR <u>Samuel Lacy</u>		25a REC'D BY REGISTRAR <u>Aug 27 1968</u>		25b REGISTRAR'S SIGNATURE <u>Charles Judge</u>



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician, it must be completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1, 2, and 3 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
12234 CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last <del>Matthew</del> Benjamin Glover			2a. DATE OF DEATH Month Day Year August 9 1968		2b. HOUR 9:14 AM	
3. SEX male		4. RACE colored		5. DATE OF BIRTH May 5, 1921		6. AGE (in years last birthday) 47 YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) Florida		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input checked="" type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md.			
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Pine Bluff State Hosp.		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) Bus Driver		12b. KIND OF BUSINESS OR INDUSTRY -			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER 709 S. Westover "five"	
14. FATHER'S NAME First Middle Last Anderson - Glover			15. MOTHER'S MAIDEN NAME First Middle Last Mattie - Grace						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown no		16b. SOCIAL SECURITY NO 267-16-8694		17. INFORMANT Records of: Address Pine Bluff State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary tuberculosis</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH unknown									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that <del>he</del> (this hospital) attended the deceased from <u>Aug. 7</u> , 1968, to <u>Aug. 9</u> , 1968, that <del>he</del> (we) last saw the deceased alive on <u>Aug. 9</u> , 1968, and that in <del>my</del> (our) opinion death occurred on the date and hour and from the causes stated above, <del>he</del> (we) (did) <del>not</del> view the body after death.									
22b. SIGNATURE <i>E. P. Ritchings</i>				DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED Aug. 9, 1968			
22d. PHYSICIAN'S NAME (Type) E. P. Ritchings, M.D.				22e. ADDRESS Pine Bluff State Hospital					
23a. BURIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE Aug. 14, 1968		23c. NAME OF CEMETERY OR CREMATORY St. Matthews Cemetery		23d. LOCATION (City or Town) (County) (State) Laurel, Delaware			
24. FUNERAL DIRECTOR <i>From the funeral home</i> J. J. Frampton and Son, Federalburg, Maryland				25a. REC'D BY REGISTRAR DATE AUG 15 1968		25b. REGISTRAR'S SIGNATURE <i>Charles J. J...</i>			

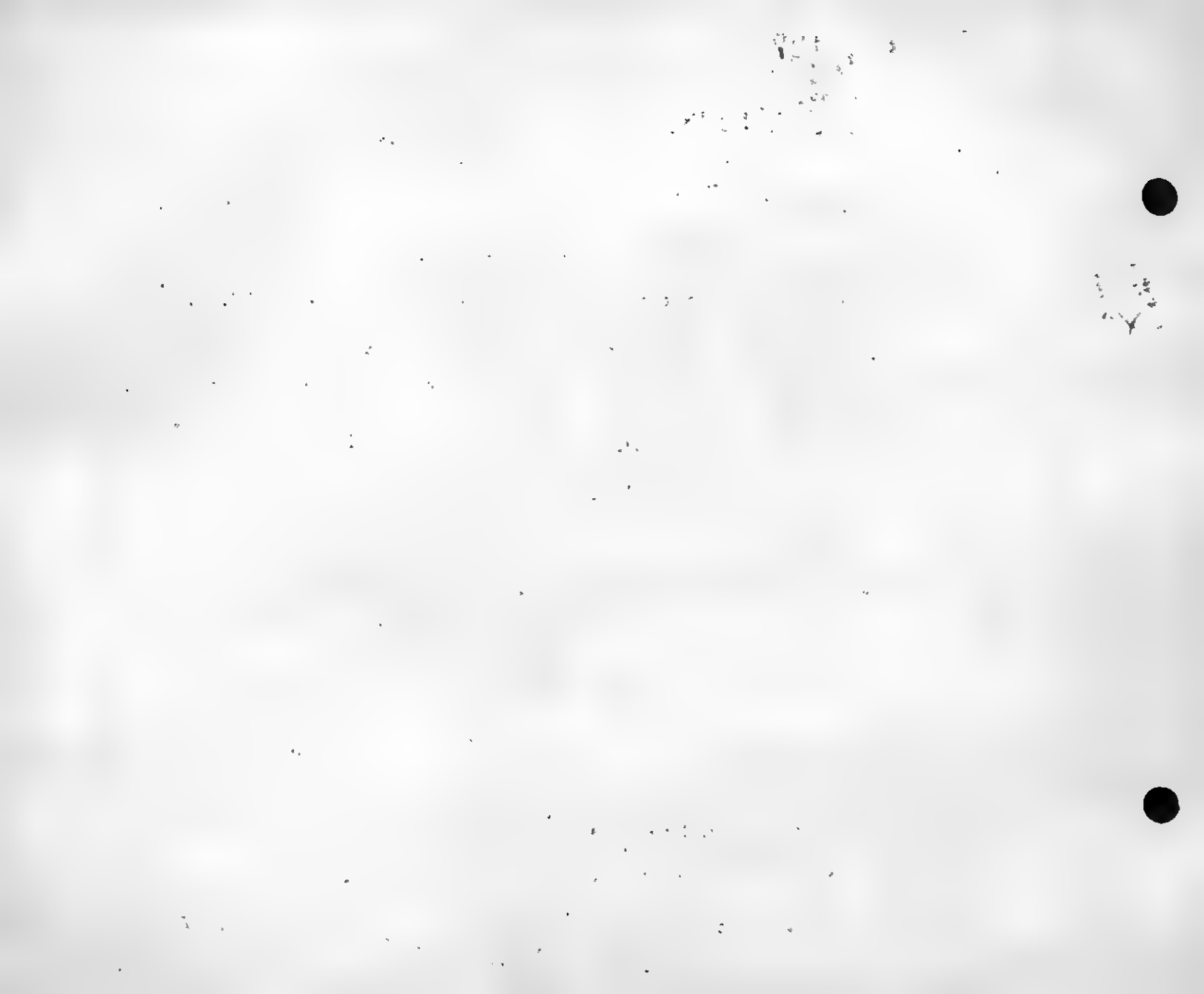




TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be completed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
12233 CERTIFICATE OF DEATH									
DECEASED-NAME (Type or print)			First	Middle	Last	2a. DATE OF DEATH		2b. HOUR	
Mary Ida Gordy						Month 8 Day 9 Year 68		7:35 AM	
3 SEX	4 RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS MIN
Female	Negro		MAY 1, 1870			98 YRS.			
7a BIRTHPLACE (State or foreign country)	7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
White Haven	U.S.A.				WICOMICO Md.				
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPAT ON (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
Salisbury			Deer's Head State Hospital						
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY	13c CITY OR TOWN		13d INSIDE CITY LIM 15? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER		
Maryland			Wicomico	Salisbury		YES <input type="checkbox"/> NO <input type="checkbox"/>	311 Poplar H. 11		
14. FATHER'S NAME			First	Middle	Last	15. MOTHER'S MAIDEN NAME			First Middle Last
NAMES			CONWAY	MARY JANE GATES					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT				
Yes, no, or unknown			220-52-755		MIRIAM WHITE - Address 71 Salisbury Md.				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Hypertensive arteriosclerotic cardiovascular disease.									Years
4120 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last 443 V									
(b) Generalized arteriosclerosis									Years
DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
Intertrochanteric fracture left femur. Osteoarthritis.									
9a DATE OF OPERATION		9b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		HOUR A.M. Month Day Year P.M. 19							
21d INJURY OCCURRED		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f LOCATION Street or R.F.D. No. City or Town County State					
While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>									
22a. I certify that (I) (has/have) attended the deceased from 3/13, 19 58, to 8/9, 19 68, that (I) (we) last saw the deceased alive on 8/9, 19 68, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do not) view the body after death.									
22b SIGNATURE					DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED
C. H. Winnacott, M. D.									8/9/68
22d. PHYSICIAN'S NAME (Type)					22e ADDRESS				
					Deer's Head State Hospital, Salisbury, Md.				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
BURIAL		8-13-68		John Wesley		White Haven Wico. Md			
24. FUNERAL DIRECTOR					ADDRESS		25a. REC'D BY REGISTRAR		
Loretta B. Jolley					Jersey Rd. Rt 42 Salisbury Md		25b. REGISTRAR'S SIGNATURE		
							DATE AUG 13 1968		



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
**12235 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1. DECEASED-NAME (Type or Print)		First <i>Howard Allen</i>		Middle <i>GOULD</i>		Last		2a. DATE KNOWN OF DEATH <input checked="" type="checkbox"/> EST. <input type="checkbox"/> Month Day Year 8 23 1968		2b. HOUR M	
3 SEX <i>male</i>	4. RACE <i>white</i>	5. DATE OF BIRTH <i>6/5/1912</i>	6. AGE (In years last birthday) <i>56</i> YRS.	7. UNDER 1 YEAR MONTHS DAYS	8. IF UNDER 24 HRS HOURS MIN.	2c. DATE PRONOUNCED DEAD Month Day Year 19			2d. HOUR M		
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>		7b. CITIZEN OF WHAT COUNTRY? <i>USA</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Wicomico</i>			Md.		
10. CITY OR TOWN OF DEATH <i>Salisbury</i>		11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) <i>Baysinger Trailer Park</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <i>Carpenter</i>		12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Wicomico</i>		13c. CITY OR TOWN <i>Salisbury</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Baysinger Trailer Park</i>			
14. FATHER'S NAME First Middle Last <i>Thomas H. Gould</i>				15. MOTHER'S MAIDEN NAME First Middle Last <i>Lydia Insley</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No or unknown) <i>Yes</i>		(If yes, War and dates of service) <i>WW II</i>		16b. SOCIAL SECURITY NO. <i>218-05-9621</i>		17. INFORMANT <i>Mrs. Howard A. Gould, Salisbury, Md.</i>			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary thrombosis</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)										APPROX. RATE INTERVAL, BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>		21b. TIME OF INJURY Month Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Philip A. Insley</i> NAME (Type)		M.D. <i>Philip A. Insley</i>		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <i>8/23/68</i>	
ADDRESS (Street, city, town, or county) <i>Salisbury-Wic-Md.</i>											
23a. BURIAL, CREMATION, REINTERMENT <i>Buried</i>		23b. DATE <i>8/26/1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Firemen's</i>		23d. LOCATION (City or Town) (County) (State) <i>Sharptown, Md.</i>					
24. FUNERAL DIRECTOR <i>Neunam Funeral Home, Sharptown, Md.</i>				ADDRESS		25a. REC'D BY REGISTRAR DATE <i>AUG 28 1968</i>		25b. REGISTRAR'S SIGNATURE <i>J. Charles Jones</i>			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 in the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12237 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)		First <b>THAIS</b>		Middle <b>CONSTANCE</b>		Last <b>GRICHIK</b>		2a. DATE KNOWN OF DEATH		Month <b>8</b>	Day <b>1</b>	Year <b>1968</b>	2b. HOUR <b>3:20</b>
3 SEX <b>Female</b>	4 RACE <b>White</b>	5 DATE OF BIRTH <b>July 30, 1924</b>	6 AGE (n years last birthday) <b>44</b> YRS	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>		2c. DATE PRONOUNCED DEAD Month <b>8</b> Day <b>1</b> Year <b>1968</b>		2d. HOUR <b>3:20</b>			
7a. BIRTHPLACE (State or foreign country) <b>New York</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Wicomico</b>							
10 CITY OR TOWN OF DEATH <b>Salisbury</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Peninsula General Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of life) <b>House wife (retired.)</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Own Home</b>							
13a. USUAL RESIDENCE (Where deceased lived if institution admission) <b>New York</b>		13b. COUNTY <b>Kings</b>		13c. CITY OR TOWN <b>Brooklyn</b>		13d. INSIDE CITY LIMITS? <b>YES</b> <input checked="" type="checkbox"/> <b>NO</b> <input type="checkbox"/>		13e. STREET AND NUMBER <b>44 East 48 St.,</b>					
14. FATHER'S NAME		First <b>Unknown</b>	Middle <b>-</b>	Last <b>Borowski</b>	15. MOTHER'S MAIDEN NAME		First <b>Constance</b>	Middle <b>-</b>	Last <b>Unknown</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) <b>no</b>		16b. SOCIAL SECURITY NO. (If yes give year or dates of service) <b>None</b>		17 INFORMANT <b>Mr. Harold Grichik, See Sec 13a.</b>		ADDRESS							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))													
PART 1 DEATH WAS CAUSED BY													
IMMEDIATE CAUSE (a) <b>Metastatic melanoma</b>													
DUE TO, OR AS A CONSEQUENCE OF													
(b) <b>Melanoma the leg</b>													
DUE TO, OR AS A CONSEQUENCE OF													
(c) <b>5 years</b>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION													
19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?													
20. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>													
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. no City or town County State									
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <b>Dr. Earl L. Royer</b>		EXAMINER'S NAME (Type)		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASS STANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED <b>8-1-1968</b>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>8-5-1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Evergreen Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Brooklyn, New York</b>							
24. FUNERAL DIRECTOR		ADDRESS <b>Hill Funeral Home Salisbury, Maryland</b>		25a. REC'D BY REG STAR <b>AUG 5 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>							



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12233

CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>Edward Henry Griffin</b>		First Middle Last		2a. DATE OF DEATH Month Day Year <b>August 1 1968</b>		2b. HOUR <b>8:55 AM</b>	
3. SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>Dec. 15, 1915</b>		6. AGE (In years last birthday) <b>52</b> YRS	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b>	
10. CITY OR TOWN OF DEATH <b>Salisbury - Peninsula General Hospital</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Hatchery Manager</b>		12b. KIND OF BUSINESS OR INDUSTRY	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Delaware</b> COUNTY <b>Sussex</b>		13b. CITY OR TOWN <b>Selbyville</b>		13c. INS. OF CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13d. STREET AND NUMBER <b>William St.</b>	
14. FATHER'S NAME First Middle Last <b>William Henry Griffin</b>				15. MOTHER'S MAIDEN NAME First Middle Last <b>Ida Benson</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>XX</b> (If yes give war or dates of service) <b>XX</b>		16b. SOCIAL SECURITY NO. <b>222-16-5557</b>		17. INFORMANT Address <b>Cecil Griffin Selbyville, Del.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Coronary Artery Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1107</b>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>11 days</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>July 21, 1968</b> , to <b>Aug 1, 1968</b> , that (I) (we) last saw the deceased alive on <b>19</b> and that in (my) (our) opinion death occurred on the date and hour and from the cause stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>David J. Gilmore</b>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>8/4/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Odd Fellows</b>		23d. LOCATION (City or Town) (County) (State) <b>Selbyville Worcester Md.</b>	
24. FUNERAL DIRECTOR <b>Peter Whaley Selbyville Del</b>				25a. REC'D BY REG STRA <b>AUG 7 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Yager</b>	





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12239

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

CERTIFICATE OF DEATH

12249

1. DECEASED NAME (Type or print)		First	Middle	Last	2a. DATE OF DEATH Month Day Year		2b. HOUR	
MARGARET HANNAH				Groton	August 19 68		10 A.M.	
3. SEX	4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR	
FEMALE	White		Aug. 18, 1909		59 YRS.		MONTHS DAYS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		
Virginia		U.S.A.				Wicomico Md.		
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury-Peninsula		General Hospital		Housewife		---		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER
Maryland		Somerset		Pocomoke				R.F.D. 1
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME						
First Middle Last		First Middle Last						
Walter -- Whitehead		Maude -- Richardson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown		16b. SOCIAL SECURITY NO		17. INFORMANT Address				
no --		220-26-3964		Mrs Pittman Carey, Pocomoke City, Md.				
18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c).)								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)								20 hrs
DUE TO, OR AS A CONSEQUENCE OF (b)								
DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)								
443X								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? Yes		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, not by medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
21a. INJURY OCCURRED White <input type="checkbox"/> Not white <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No City or Town County State				
22a. I certify that (I) (this hospital) attended the deceased from Aug 18, 1968, to Aug 19, 1968, that (I) (we) last saw the deceased alive on Aug 19, 1968, and that in my (our) opinion death occurred on the date and hour and from the causes stated above. (I) (we) (d'd) (did not) view the body after death.								
22b. SIGNATURE				22c. DATE SIGNED				
John G. Bulkeley M.D.				Aug 27 1968				
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS				
John G. Bulkeley				Salisbury, Maryland				
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial		8-21-1968		First Baptist		Pocomoke City -Wor.-Md.		
24. FUNERAL DIRECTOR				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
Robert H. Watson				AUG 27 1968		Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 and should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201												
12240 CERTIFICATE OF DEATH												
1. DECEASED-NAME (Type or print) <b>SADIE R</b>			First Middle Last			2a. DATE OF DEATH Month Day Year <b>AUGUST 25 1968</b>			2b. HOUR <b>9:15 PM</b>			
3 SEX <b>FEMALE</b>		4 RACE <b>C</b>		5 DATE OF BIRTH <b>MAY 1 1901</b>			6 AGE (in years last birthday) <b>67</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN	
7a. BIRTHPLACE (State or foreign country) <b>Wicomico</b>		7b. CITIZEN OF WHAT COUNTRY? <b>Salisbury Md</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b> Md.						
10. CITY OR TOWN OF DEATH <b>Salisbury-Peninsula General Hospital</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp tol give street address) <b>Salisbury-Peninsula General Hospital</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Domestic</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>WHS H</b>				
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Md</b>		13b. COUNTY <b>Salisbury</b>		13c. CITY OR TOWN <b>Salisbury</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>Rural</b>				
14 FATHER'S NAME First Middle Last <b>Severn Harmon</b>				15 MOTHER'S MAIDEN NAME First Middle Last <b>Caroline Block</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, No, or UNKNOWN) <b>No</b>		16b. SOCIAL SECURITY NO <b>216-46-2887</b>		17 INFORMANT <b>Florence Harmon</b> Address								
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1: DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Renal Failure</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Cardiovascular Accident</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>???</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>36 hours</b> <b>5 days</b>		
PART 2: OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Left Lung Lobectomy</b> <b>3 days</b>												
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)								
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No		City or Town		County		State		
22a. I certify that (I) (this hospital) attended the deceased from <b>August 21, 1968</b> , to <b>August 25, 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug 25 1968</b> and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>G. Herbert Semple</b>		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>8/26/68</b>						
22d. PHYSICIAN'S NAME (Type) <b>G. Herbert Semple</b>		22e. ADDRESS <b>Salisbury, Md 21801</b>										
23a. BURIAL, CREMATION, REMOVAL Specified <b>Burial</b>		23b. DATE <b>May 30-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Berens Corn</b>		23d. LOCATION (City or Town) (County) (State) <b>Frederick Wicomico Md</b>						
24. FUNERAL DIRECTOR <b>Baker West</b>				ADDRESS		25a. REC'D BY REGISTRAR <b>SEP 3 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				

1904



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## 1224 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print) <b>ROBERT</b>		First <b>MARTIN</b>		Last <b>HARRIS</b>		2a DATE KNOWN OF DEATH <input checked="" type="checkbox"/> Month <b>8</b> Day <b>15</b> Year <b>1968</b>			2b HOUR <b>12:50</b> AM <input checked="" type="checkbox"/> PM			
3 SEX <b>Male</b>	4 RACE <b>AA</b>	5 DATE OF BIRTH <b>8-16-51</b>	6 AGE (In years not birthday) <b>16</b> YRS	IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b>		IF UNDER 24 HRS HOURS <b>0</b> MIN <b>0</b>		2c DATE PRONOUNCED DEAD Month <b>8</b> Day <b>15</b> Year <b>1968</b>		2d HOUR <b>12:50</b> AM <input checked="" type="checkbox"/> PM		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Wicomico</b>						
10 CITY OR TOWN OF DEATH <b>Salisbury</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) <b>616 Germania Circle</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY <b>IVE CARE PROGRAM</b>						
13a USUAL RESIDENCE (Where deceased lived, if not institution) STATE <b>Md.</b>		13b COUNTY <b>Wicomico</b>		13c CITY OR TOWN <b>Salisbury</b>		13d INSIDE CITY LIMITS? <input checked="" type="checkbox"/> YES <input type="checkbox"/> NO		13e STREET AND NUMBER <b>616 Germania Circle</b>				
4 FATHER'S NAME <b>Robert</b>		First <b>Harris</b>		Last <b>Harris</b>		15 MOTHER'S MAIDEN NAME <b>Hazel</b>		First <b>Snell</b>		Last <b>Snell</b>		
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, or unknown)		16b SOCIAL SECURITY NO.		17 INFORMANT <b>Hazel Harris</b>		ADDRESS <b>616 Germania Circle</b>		City <b>Salisbury</b>			State <b>Md.</b>	
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Shotgun wound of abdomen</b> <b>765X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>minutes</b>		
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>761X</b>												
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year <b>8-15-68</b> HOUR A.M. <b>12:25</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18) <b>Shot by father during argument.</b>								
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <b>own home</b>		21f LOCATION Street or R.F.D. No. <b>616 Germania Circle</b> City or Town <b>Salisbury</b> County <b>Wic.</b> State <b>Md.</b>								
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input checked="" type="checkbox"/> Undetermined manner <input type="checkbox"/>												
ACTUAL SIGNATURE <b>Earl L. Royer, M.D.</b>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b DATE SIGNED <b>August 16, 1968</b>				
EXAMINER'S NAME (Type) <b>409 Camden Ave., Salisbury, Md.</b>				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				
ADDRESS (Street, city, town, or county)				23a BURIAL, CREMATION REMOVAL (Specify) <b>BURIAL</b>				23b DATE <b>8-18-68</b>		23c NAME OF CEMETERY OR CREMATORY <b>Green Acres</b>		
24 FUNERAL DIRECTOR <b>Jolley Funeral Home, Salisbury, Md.</b>				23d LOCATION (City or Town) <b>Salisbury</b> (County) <b>Wic.</b> (State) <b>Md.</b>				25a REC'D BY REGISTRAR <b>AUG 22 1968</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>		

1881

TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
30M REV 1-68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
12242 CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year			2b HOUR
Charles Augustus Hawkins						August 11 1968			11:05
3. SEX	4 RACE		5. DATE OF BIRTH			6. AGE (In years last birthday)		7. IF UNDER 1 YEAR MONTHS DAYS	
male	colored		Oct. 20, 1894			73 YRS			
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Pennsylvania		U.S.A.				Wicomico Md.			
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
Salisbury			Pine Bluff State Hosp.			Railroad Worker		-	
13a USJAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d INSIDE CITY LIM TS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER
Maryland			Talbot		Easton		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		Taylor's Avenue
14 FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
Louis - Hawkins			Amanda - Dates						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT				
No -			214-16-4932		Records of: Address Pine Bluff State Hospital				
18. CAUSE OF DEATH (Enter only one cause per line far (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of bladder									unknown
DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									
DUE TO, OR AS A CONSEQUENCE OF									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
1816									
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. ALTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State
22a I certify that (X) (this hospital) attended the deceased from Aug. 7, 1968, to Aug. 11, 1968, that (X) (we) last saw the deceased alive on Aug. 11, 1968, and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above. (X) (we) (did) (did not) view the body after death.									
22b SIGNATURE			22c. DATE SIGNED						
E. P. Ritchings			Aug. 12, 1968						
22d. PHYSICIAN'S NAME (Type)			22e. ADDRESS						
E. P. Ritchings			Pine Bluff State Hospital						
23a BURIAL, CREMATION, REMOVAL SPECIFY		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
Burial		8/18/68		Old Chapel		Near Cordova Talbot Md.			
24 FUNERAL DIRECTOR			ADDRESS			25a RECD BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Barbara L. Dashiell			426 Dover St. Easton			DATE AUG 16 1968		J. Charles Judge	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
12243										
1. DECEASED NAME (Type or print) <b>IRIS Irene Henry</b>			2a. DATE OF DEATH Month <b>4</b> Day <b>68</b> Year <b>1968</b>			2b. HOUR <b>9:30</b> AM				
3 SEX <b>FEMALE</b>		4 RACE <b>WHITE</b>		5 DATE OF BIRTH <b>November 21, 1913</b>		6 AGE (In years lost birthday) <b>54</b> YRS.		IF UNDER 1 YEAR MONTHS <b>0</b> DAYS <b>0</b> HOURS <b>0</b> MIN		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b> Md.				
10. CITY OR TOWN OF DEATH <b>Salisbury - Peninsula General Hospital</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Bookkeeper</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>Clothing Store</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Res dence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>Salisbury</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>825 S. Division Street</b>	
14. FATHER'S NAME First <b>Lance</b> Middle <b>Merrill</b> Last <b>Insley</b>			15. MOTHER'S MAIDEN NAME First <b>Mary</b> Middle <b>Ellen</b> Last <b>Horsman</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>214-10-7211</b>		17. INFORMANT (Husband) <b>Mr. S. Roland Henry, Salisbury, Maryland</b> Address <b>825 S. Div. St.</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Myocardial Infarction</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <b>4109</b> (b) <b>Coronary Heart Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>4201</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State		
22a. I certify that (I) (the hospital) attended the deceased from <b>July 1, 1968</b> , to <b>Aug 7, 1968</b> , that (I) (we) last saw the deceased alive on <b>July 25, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (do) view the body after death.										
22b. SIGNATURE <b>Thomas C. Hill, Jr.</b>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>8-4-68</b>			
22d. PHYSICIAN'S NAME (Type) <b>THOMAS C. HILL, JR.</b>					22e. ADDRESS <b>Pine Bluff Rd - Salisbury Md.</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Aug. 7, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>		23d. LOCATION (City or Town) (County) (State) <b>Salisbury, Wicomico, Maryland</b>				
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>					25a. REC'D BY REGISTRAR DATE <b>AUG 8 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles J. J...</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
12244 CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) First Middle Last <b>ARTHUR HINMAN</b>			2a. DATE OF DEATH Month Day Year <b>AUGUST 6 1968</b>			2b. HOUR <b>8 P.M.</b>					
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>August 13, 1891</b>		6. AGE (In years last birthday) <b>76</b> YRS		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Delaware</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b> Md.					
1d. CITY OR TOWN OF DEATH <b>Salisbury - Peninsula General Hospital</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Custodian</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if at institution, residence before admission) STATE <b>Md.</b>		13b. COUNTY <b>Somerset</b>		13c. CITY OR TOWN <b>Crisfield</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>8 Somerset Ave.</b>			
14. FATHER'S NAME First Middle Last <b>Leed Hinman</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>Lydia Cheers</b>								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give war or dates of service) <b>No</b>		16b. SOCIAL SECURITY NO.		17. INFORMANT Address <b>Mrs. Fannie Hinman, Crisfield, Md.</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma stomach</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>4 mos.</b>											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>151X</b>											
19a. DATE OF OPERATION <b>4/5/68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <b>Carcinoma stomach</b>			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC.)		21f. LOCATION Street or RFD No		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <b>3-31</b> , 1968, to <b>8-6</b> , 1968, that (I) (we) last saw the deceased alive on <b>8-6</b> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Nevins W. Todd</b>		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>8-8-68</b>					
22d. PHYSICIAN'S NAME (Type) <b>NEVINS W. TODD</b>		22e. ADDRESS <b>MEDICAL CENTER, SALISBURY, MARYLAND</b>									
23a. BURIAL, CREMATION, REMOVA (Specify) <b>Burial</b>		23b. DATE <b>8/9/1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Asbury Cemetery</b>		23d. LOCATION (City or Town) (County) (State) <b>Crisfield, Somerset, Md.</b>					
24. FUNERAL DIRECTOR <b>James L. Hinman</b>		ADDRESS <b>Prince ss Anne</b>		25a. REC'D BY REGISTRAR DATE <b>AUG 12 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

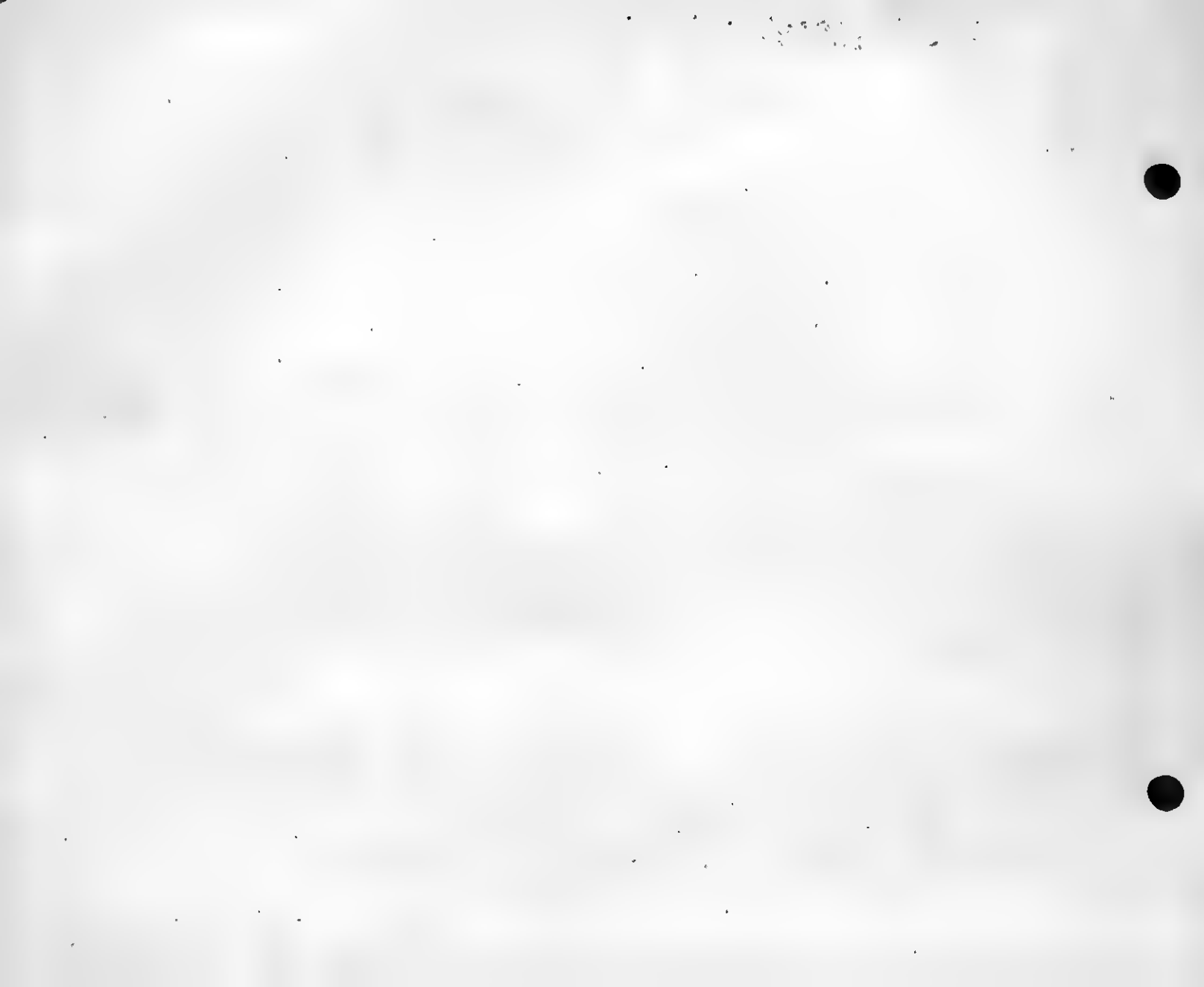


# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 304 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
12245 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF EST. - DEATH MATED <input type="checkbox"/> Month Day Year		2b HOUR
ANNIE		BLANCHE		HITCHENS				Aug. 11 1968		M
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (in years last birthday)	7 UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c DATE PRONOUNCED DEAD Month Day Year	2d HOUR
Female	White	Feb. 2, 1885		83					August 11 1968	M
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Maryland		USA				WICOMICO		Md		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY				
Salisbury		Peninsula General Hospital		Housewife						
13a USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER		
Maryland		Wicomico		Salisbury				R.D.5, Parsons Road		
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S MAIDEN NAME		First Middle Last
Gabriel		Webster						Mary E.		Hoffman
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT (Son)		R.D.5 ADDRESS		Parsons Road		
No		216-48-5013		Mr. Clarence E. Hitchens, Salisbury, Maryland						
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u>										<u>1 year</u>
4109 DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>AS CVD</u>										
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION										20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>
19b CONDITION FOR WHICH OPERATION WAS PERFORMED?										
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>										21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19
21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)										
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>										21e LOCATION Street or R.F.D. No City or Town County State
21f PLACE OF INJURY (At home, farm, street, factory, office building, etc.)										
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE <u>Dr. Earl L. Royer</u> M.D.										22b DATE SIGNED August 12 / 1968
EXAMINER'S NAME (Type) 409 Camden Ave., Salisbury, Md.										DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>
ADDRESS (Street, city, town, or county)										
23a BURIAL, CREMATION, REMOVAL (Specify)										23b DATE
Burial										August 14, 1968
23c NAME OF CEMETERY OR CREMATORY										23d LOCATION (City or Town) (County) (State)
Shad Point Cemetery										Salisbury, Wicomico, Maryland
24 FUNERAL DIRECTOR										25a REC'D BY REGISTRAR
HOLLOWAY & COMPANY, SALISBURY, MARYLAND										25b REGISTRAR'S SIGNATURE DATE AUG 14 1968



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
12246 CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR	
Herbert		-		Holston		Holstein		August 15 1968		7:01 PM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		8. IF UNDER 24 HRS.	
male		white		May 9, 1929		39 YRS.		MONTHS DAYS		HOURS MIN.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.			
Maryland		U.S.A.				Wicomico					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury		Pine Bluff State Hosp.		none		-					
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Wicomico		Pittsville				-			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
George B. Holstein								Lydia Ellen Wyatt			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT		Address					
No		-		none		records of Pine Bluff State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Pulmonary Tuberculosis</u> <u>211.9</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO, OR AS A CONSEQUENCE OF (c) <u></u>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>6 months</u>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u></u>											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d. INJURY OCCURRED While <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from <u>June 1</u> , 19 <u>68</u> , to <u>Aug. 15</u> , 19 <u>68</u> , that (X) (we) last saw the deceased alive on <u>Aug. 15</u> , 19 <u>68</u> , and that in (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <u>E. P. Ritchings</u>						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <u>Aug. 16, 1968</u>			
22d. PHYSICIAN'S NAME (Type) <u>E. P. Ritchings, M.D.</u>						22e. ADDRESS <u>Pine Bluff State Hospital</u>					
23a. BURIAL, CREMATION, REMOVAL, (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		Aug. 18, 1968		Line Cemetery		Sussex Whitesville, Del.					
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE					
<u>Charles Nelson</u>		<u>Frankford, Del.</u>		<u>SEP 9 1968</u>		<u>Charles Judge</u>					

— 1925 —





# FOR STATE HEALTH DEPT.

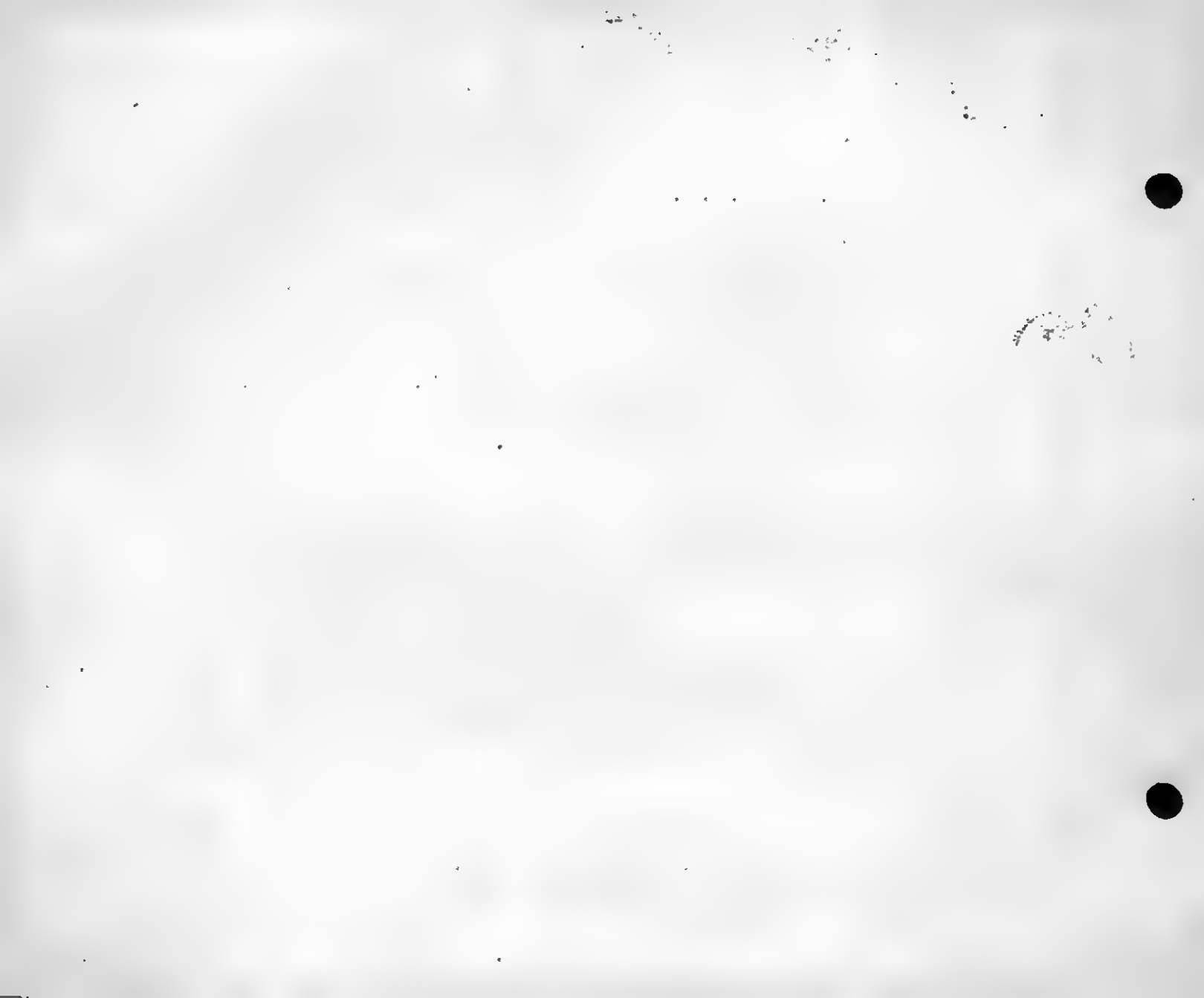
10-DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil. Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## 12247 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF ESTI- DEATH MATED <input checked="" type="checkbox"/> 8-14-68 19 12:30M		2b HOJR
BENJAMIN WALTER HUDSON							
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD Month 8 Day 14 Year 19 12:30M	2d HOUR
M	W	8-10-54	14 YRS				
7a BIRTHPLACE (State or foreign country)		7b C. I. ZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH	
Mississippi		U.S.A.				Wicomico Md	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Salisbury		Peninsula General		student			
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
Md.		Wicomico		Salisbury		Rt. 5, Old Quantico Rd.	
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First Middle Last
Walter B. Hudson					Jane		Hearthway
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS	
No				Walter B. Hudson (father)			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))							
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Hemorrhage due to Ruptured Aorta</u>							
DUE TO, OR AS A CONSEQUENCE OF							
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last							
(b) DUE TO, OR AS A CONSEQUENCE OF							
(c)							
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
<u>Fr of skull</u>							
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
		4:30 PM 8-13-68		Fell off tractor and was run over by same.			
21d INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No. City or Town County State			
		farm		Pemberton Drive, Salisbury, Wic., Md.			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspect on <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
22b DATE SIGNED		August 15, 1968					
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>					
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>					
Earl L. Royer, M.D.		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>					
409 Camden Ave., Salisbury, Md		ADDRESS (Street, city, town, or county)					
23a BURIAL CREMATION REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)	
Burial		8-16-68		Christian Church Cemetery, Snow Hill, Nor., Md			
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Dennis Funeral Home, Snow Hill, Md.				DATE AUG 19 1968		Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. The permit should be removed from the certificate and placed in the funeral home. The permit should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
12248 CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) <b>LESLIE</b>		First	Middle	Last	2a DATE OF DEATH Month Day Year	2b HOUR 7 <sup>46</sup> / <sub>P</sub> M
3 SEX <b>MALE</b>	4 RACE <b>White</b>	5. DATE OF BIRTH <b>Feb 5, 1893</b>		6 AGE (In years last birthday) <b>75 YRS</b>	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) <b>Ky.</b>	7b CITIZEN OF WHAT COUNTRY? <b>US</b>	8 MARRIED WIDOWED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Wicomico</b>		Mo	
10 CITY OR TOWN OF DEATH <b>Salisbury-Peninsula</b>	11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>General Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b KIND OF BUSINESS OR INDUSTRY	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Del</b>	13b COUNTY <b>Sussex</b>	13c CITY OR TOWN <b>Delmar</b>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	13e. STREET AND NUMBER <b>Rd I</b>		
14. FATHER'S NAME First Middle Last <b>John Austin Hudson</b>		15 MOTHER'S MAIDEN NAME First Middle Last <b>Mary Saunders</b>				
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>yes</b>		16b SOCIAL SECURITY NO. <b>218-07-6061</b>		17 INFORMANT Address <b>Clara J. Hudson Delmar, Del.</b>		
18. CAUSE OF DEATH (Enter on any one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Pulmonary insufficiency.</b> <b>491X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Pulmonary emphysema.</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Chronic Bronchitis &amp; emphysema.</b>						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>years</b> <b>years.</b>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>5020 ASCVD &amp; renal failure</b>						
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State		
22a. I certify that (I) (this hospital) attended the deceased from <b>8-9-68</b> , 19__, to <b>8-13-68</b> , 19__, that (I) (we) last saw the deceased alive on <b>8-13-68</b> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.						
22b SIGNATURE <b>Joseph C. Fitzgerald MD.</b>				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <b>13 Aug 68.</b>
22d PHYSICIAN'S NAME (Type) <b>Joseph C. Fitzgerald</b>				22e. ADDRESS <b>Medical Center Salisbury Md.</b>		
23a BURIAL, CREMATION, OR DISPOSAL (Specify)	23b. DATE <b>8/16/68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>St Stephen's</b>		23d. LOCATION (City or Town) (County) (State) <b>Delmar Sussex Del.</b>		
24 FUNERAL DIRECTOR <b>William J. Ward</b>		ADDRESS <b>Delmar Del.</b>		25a REC'D BY REGISTRAR DATE <b>AUG 16 1968</b>		25b REGISTRAR'S SIGNATURE <b>Charles Young</b>

1000

1000

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FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

# MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1. DECEASED NAME (Type or Print)		Middle		Last		2a. DATE KNOWN OF DEATH		Month		Day		Year		2b. HOUR					
GEORGE		LEBERT		HUGHES		8-6-68		19		7		45		A.M.					
3. SEX	4. RACE	5. DATE OF BIRTH		6. AGE (in years)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c. DATE PRONOUNCED DEAD		Month		Day		Year		2d. HOUR	
M	AA	12-8-1888		84 YRS		MONTHS		DAYS		8		6		1968		9		A.M.	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED		NEVER MARRIED		9. COUNTY OF DEATH											
White Haven		U.S.A.		WIDOWED		DIVORCED		Wicomico											
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY													
Tyaskin		Route 1																	
13a. USLA. RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER											
Md.		Wicomico		Tyaskin		YES		NO		Route 1, Box 27									
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME																	
Isaac Hughes		Ebbie Hainwright																	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO.		17. INFORMANT		ADDRESS													
		219-34-3366		Leslie Chase		Spring Hill Rd. #5													
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))		PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a)		DUE TO, OR AS A CONSEQUENCE OF															
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.		(b)		DUE TO, OR AS A CONSEQUENCE OF															
		(c)																	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)		42																	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?		YES		NO											
21a. EXTERNAL CAUSE WAS PRIMARY OR CONTRIBUTING		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)															
21d. INJURY OCCURRED		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State									
WHILE AT WORK		NOT WHILE AT WORK																	
22a. I certify that I took charge of the remains described above, held an Autopsy		Inspection		Inquiry		and in my opinion death resulted from.		Natural causes		Accident		Suicide		Homicide		Undetermined manner			
ACTUAL SIGNATURE		Earl L. Royer, M.D.		CHIEF MEDICAL EXAMINER		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER		22b. DATE SIGNED		Aug. 6, 1968							
EXAMINER'S NAME (Type)		409 Camden Ave., Salisbury, Md.		ADDRESS (Street, city, town, or county)															
23a. BURIAL, CREMATION REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)									
Burial		8-11-68		Grove Methodist		Newtown		Wicomico		Md.									
24. FUNERAL DIRECTOR		ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE													
Jolley Funeral Home, Salisbury, Md.				DATE		AUG 13 1968													

SPS 11

427

11-11-11

# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

12250

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

## MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> Month		Day		Year		2b HOUR	
CLARENCE						JOHNSON		8-11-68		19		1		10		A.M.	
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		Month		Day		Year	
M	AA	Sept. 12 1934		33 YRS		MONTHS		DAYS		HOURS		MIN		8		11	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9 COUNTY OF DEATH											
Va.		U.S.A.		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Viconico											
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY											
Salisbury		Peninsula General		Laborer		Factory											
13a USUAL RESIDENCE (Where deceased lived, if institution on admission) STATE		13b CITY OR TOWN		13c RES DE CITY, MD		13d STREET AND NUMBER											
Va.		Accomack		Horntown		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
14 FATHER'S NAME		First		Middle		Last		15 MOTHER'S M.A.DEN NAME		First		Middle		Last			
Isaac						Johnson		Ethel						Wallop			
6a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17. INFORMANT		ADDRESS											
No		220-32-7902		Josephine Johnson		Horntown, Va.											
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))																APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Bullet wound of heart																sudden	
DUE TO, OR AS A CONSEQUENCE OF																	
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost																	
DUE TO, OR AS A CONSEQUENCE OF																	
DUE TO, OR AS A CONSEQUENCE OF																	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)																	
481																	
19a DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?									
								YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>									
21a EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH				21b TIME OF INJURY Month, Day, Year				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
				3:45 PM 8-11-68				Shot by assailant during argument.									
21d INJURY OCCURRED				21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or RFD No				City or Town					
WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>				dance hall				Horntown				Va.					
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input checked="" type="checkbox"/> , Undetermined manner <input type="checkbox"/>																	
ACTUAL SIGNATURE				CHIEF MEDICAL EXAMINER				22b. DATE SIGNED									
Earl L. Royer M.D.								August 13, 1968									
EXAMINER'S NAME (Type)				DEPUTY MEDICAL EXAMINER				ADDRESS (Street, city, town, or county)									
409 Camden Ave., Salisbury, Md																	
23a BURIAL, CREMATION, REMOVAL (Specify)				23b DATE				23c NAME OF CEMETERY OR CREMATORY				23d LOCATION (City or Town)					
Burial				8-17-68				Tabernacle Bapt. Cem.				Horntown Accomack Va.					
24 FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR				25b REGISTRAR'S SIGNATURE					
Thorton & Savage, New Church, Va.								AUG 16 1968				Charles Judge					





# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form RM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR		
MARGARET L. KENTON						Month Day Year		M		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS HOURS MIN.		2c. DATE PRONOUNCED DEAD		
Female	White	11-19-1910	57 YRS					Month Day Year		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		2d. HOUR		
Maryland		U.S.A.				Wicomico		M		
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury			Peninsula General Hospital							
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		3a. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Baltimore		Arbutus				5231 Benson Avenue	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
George Romoser			Louise Raycob							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS		21227	
					Mr. Robert P. Kenton, Jr.		5231 Benson Ave.			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u> <u>4109</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?				
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH			21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
			19							
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No			City or Town County State	
22a. I certify that I took charge of the remains described above, held on death resulted from. Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER <input type="checkbox"/>			ASS STANT MEDICAL EXAMINER <input type="checkbox"/>			22b. DATE SIGNED	
EXAMINER'S NAME (Type)			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			ADDRESS (Street, city, town, or county)			8-20-68	
23a. BURIAL CREMATION REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL			8-22-1968		Meadowridge Cemetery		Howard County, Maryland			
24. FUNERAL DIRECTOR					ADDRESS		25a. RECEIVED BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
Howard H. Hubbard, 4107 Wilkens Ave.					21229		AUG 22 1968		John H. Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers (pages 1 and 2) should be filed with the State Dept of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH										
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
12252 CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or print)			First Middle Last			2a DATE OF DEATH		2b HOUR		
NICHOLAS			FREDERICK			KIEFFER, Sr.		8 13 1968 957 P M		
3 SEX		4 RACE		5 DATE OF BIRTH		6 AGE (In years lost birthday)		IF UNDER 1 YEAR MONTHS DAYS		
Male		White		Dec. 10, 1906		61 YRS				
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
New York		U.S.A.				Wicomico		Md		
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Salisbury			Peninsula General Hospital			Retired Blacksmith		Owner		
13a U.S.A. RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY, I.M.T.S? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Wicomico		Salisbury		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		Schumaker Lane	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME							
First Middle Last			First Middle Last							
Nicholas J. Kieffer			Frieda Maria Hank							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input checked="" type="checkbox"/> No <input type="checkbox"/> (If yes give war or dates of service)			16b SOCIAL SECURITY NO		17 INFORMANT Address					
No			097-05-2849		Mrs. Irma P. Kieffer, Sec 13					
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <i>Conjunctive Heart Failure</i>									10 days	
DUE TO, OR AS A CONSEQUENCE OF (b) <i>Myocardial Infarction</i>									10 days	
DUE TO, OR AS A CONSEQUENCE OF (c) <i>Coronary Artery Disease</i>										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d INJURY OCCURRED at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
					8/3/68 8/13/68					
22a. I certify that (I) (this hospital) attended the deceased from 8/3/68 to 8/13/68, that (I) (we) saw the deceased alive on 8/13/68 and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b SIGNATURE					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED			
22d PHYSICIAN'S NAME (Type) Dr. Q. J. Burton					22e ADDRESS		8-14-1968			
					Salisbury, Maryland					
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)				
Burial		8-16-1968		Wicomico Memorial Park		Salisbury, Wicomico, Maryland				
24 FUNERAL DIRECTOR					25a REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE			
Hill Funeral Home Salisbury, Maryland					DATE AUG 19 1968		J Charles Judge			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH											
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
12253											
CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print)						2a. DATE OF DEATH			2b. HOUR		
First Middle Last Ruth Elizabeth Killmon						Month Aug. Day 31 Year 1968			M		
3 SEX		4 RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR		IF UNDER 24 HRS.	
Female		White		4/10/92		76 YRS.		MONTHS DAYS		HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH					
Virginia		U.S.A.				Wicomico		Md.			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury, Maryland		Wicomico Nursing Home		Housewife		Domestic					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE		13b. CITY OR TOWN		13c. INSIDE CITY, LIMITS?		13d. STREET AND NUMBER					
Virginia		Accomack Bloxom		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>							
14. FATHER'S NAME First Middle Last				15. MOTHER'S MAIDEN NAME First Middle Last							
John R. Hopkins				Elizabeth Bull							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)		16b. SOCIAL SECURITY NO		17. INFORMANT Address							
				Mrs. Kenneth Miles - Bloxom, Va.							
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c))										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) Congestive heart failure										1 wk	
DUE TO, OR AS A CONSEQUENCE OF (b) degenerative heart disease										yrs.	
DUE TO, OR AS A CONSEQUENCE OF (c) generalized arteriosclerosis											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
4221 fracture of hip											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY?		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
				YES <input type="checkbox"/> NO <input type="checkbox"/>							
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
		P.M. 19									
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at home		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State							
22a. I certify that (I) (this hospital) attended the deceased from 8/1, 1968, to 8/31, 1968, that (I) (we) last saw the deceased alive on 8/30, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE				DEGREE		ATTENDING PHYS.		MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED	
										8/30/68	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS							
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		9/2/68		Mt. Holly Cem.		Onancock Accomack Va.					
24. FUNERAL DIRECTOR				ADDRESS		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
John J. Williams				Onancock, Va.		DATE SEP 3 1968		Charles Judge			



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VR A15 (4)  
15M 9/59

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF STATISTICAL RESEARCH AND RECORDS — BALTIMORE 1, MARYLAND

12254

CERTIFICATE OF DEATH

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Willards</u>		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Willards</u>	
d. NAME OF HOSPITAL (If not in hospital, give street address) <u>Box 115</u>		d. STREET ADDRESS <u>Box 115</u>	
e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
3. NAME OF DECEASED (Type or print) First <u>Calvin</u> Middle <u>Chester</u> Last <u>Lowe</u>		4. DATE OF DEATH Month <u>August</u> Day <u>18</u> , Year <u>1968</u>	
5. SEX <u>Male</u>	6. COLOR OR RACE <u>caucasian</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>12 September 1918</u>
9. AGE (In years last birthday) <u>49</u> yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>Laborer</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>Wayne Pump Co.</u>	
11. BIRTHPLACE (State or foreign country) <u>Delaware</u>		12. CITIZEN OF WHAT COUNTRY? <u>USA</u>	
13. FATHER'S NAME <u>Thomas Lowe</u>		14. MOTHER'S MAIDEN NAME <u>Mary Hester Parker</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, name unknown) <u>No</u> (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. <u>221-05-1788</u>	
17. INFORMANT <u>Pauline Lowe; Box 115; Willards, Maryland</u>		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>carcinoma of brain</u> <u>143x</u> DUE TO <u>(diagnosed at autopsy as metastasis)</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. DUE TO <u>(Primary lesion in brain)</u> (c) _____		INTERVAL BETWEEN ONSET AND DEATH <u>6 mos.</u>	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>stroke</u>		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. _____ p. m. _____ 19 _____		20d. INJURY OCCURRED While <input type="checkbox"/> Not while at work <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office, bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that (I) (this hospital) attended the deceased from <u>April 1968</u> to <u>8-18-</u> 1968, that (I) <u>was</u> lost saw the deceased alive and <u>8-18</u> 1968, and that death occurred at <u>8 A.</u> M. from the causes and on the date stated above			
22a. SIGNATURE <u>Frank Lewis</u>		22b. DATE SIGNED	
22c. PHYSICIAN'S NAME (Type) <u>Frank Lewis</u>		22d. ADDRESS <u>Willards Md.</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>burial</u>		23b. DATE THEREOF <u>21 August 68</u>	
23c. NAME OF CEMETERY OR CREMATORY <u>Lewis</u>		23d. LOCATION (City, town, or county) (State) <u>Willards, Maryland</u>	
24. FUNERAL DIRECTOR'S SIGNATURE <u>James P. ...</u>		25a. REC'D BY REGISTRAR <u>Charles Judge</u>	
ADDRESS <u>Millsboro, Delaware</u>		25b. REGISTRAR'S SIGNATURE	



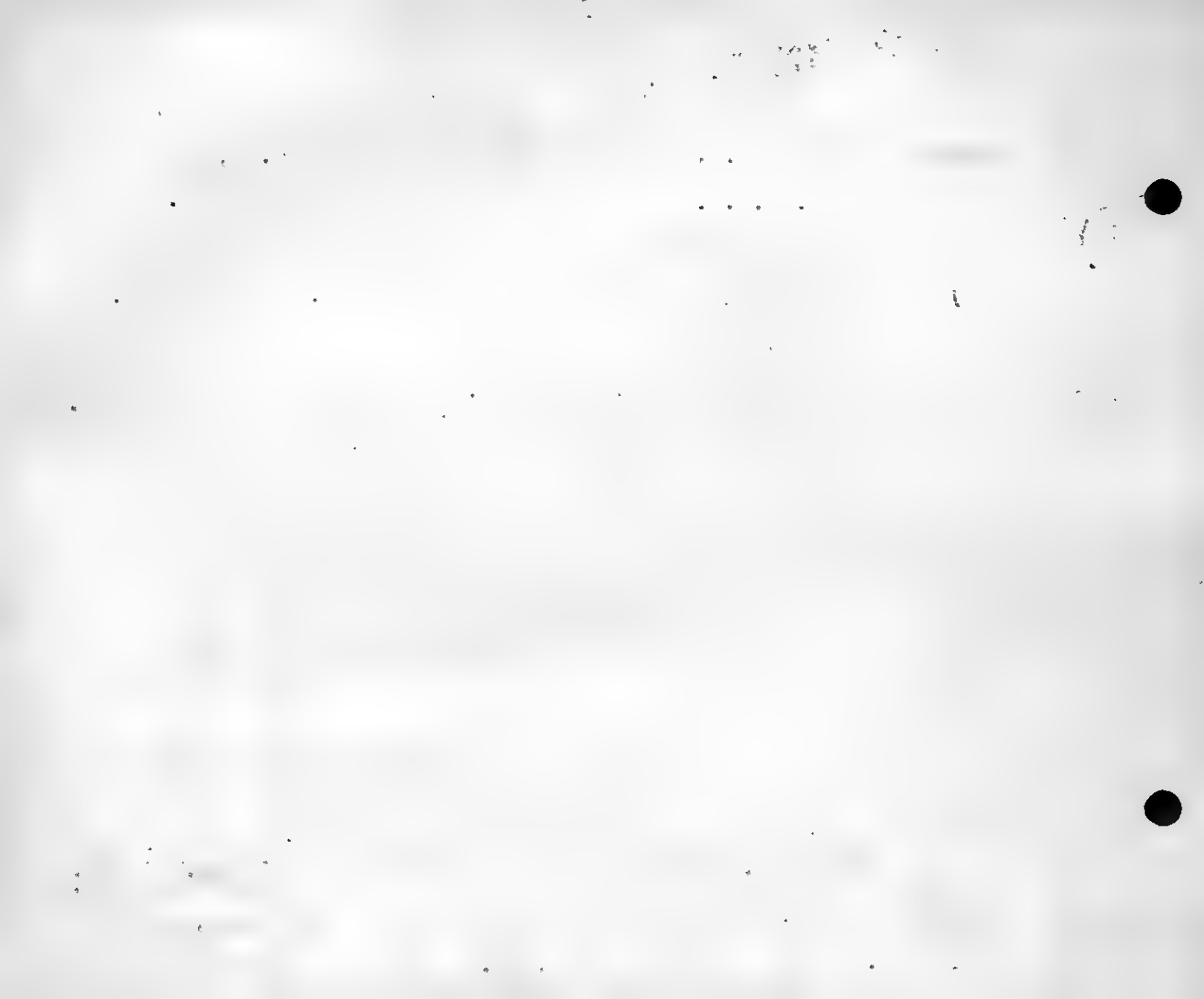


# FOR STATE HEALTH DEPT.

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TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. See pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

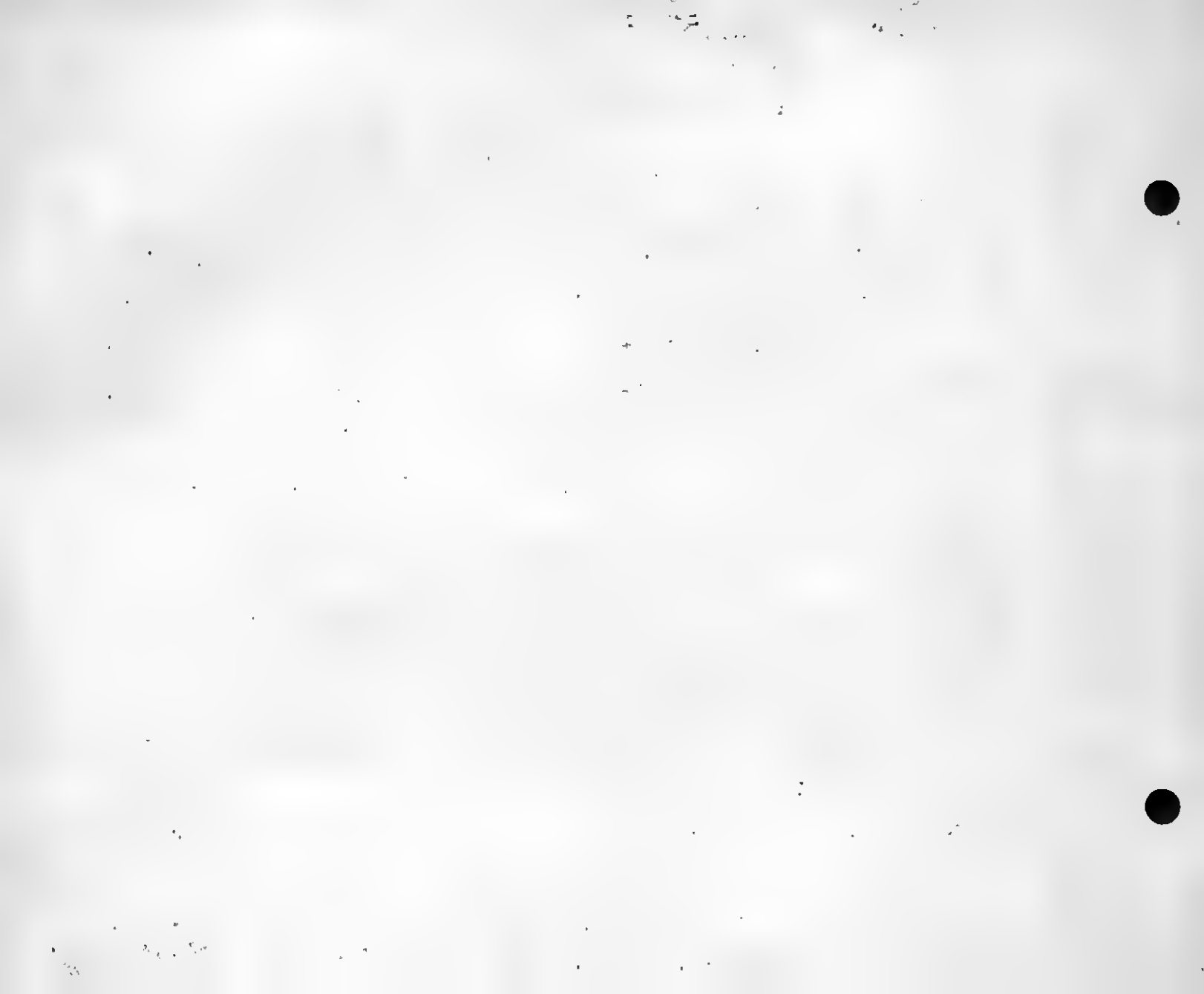
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
12255 MEDICAL EXAMINER'S CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR	
GRANVILLE LEE MARSHALL						EST MATED <input type="checkbox"/> AUG. 18 1968		M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		7. DATE PRONOUNCED DEAD		2d. HOUR	
Male	White	NOV. 7, 1929	38 YRS	MONTHS	DAYS	AUG. 18, 1968		9 P M	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		Md.	
SOMERSET CO.		U.S.A.				WICOMICO CO.			
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY	
SALISBURY			PENINSULA GENERAL HOSPITAL			TRUCK DRIVER			
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. STREET AND NUMBER	
MARYLAND			SOMERSET			PRINCESS ANNE		S. SOMERSET AVE.	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
EDWARD MARSHALL			DOROTHY LINTON						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT ADDRESS			
YES			KOREAN WAR 215-26-5051			MRS. AGNES MARSHALL PRINCESS ANNE			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Thrombosis</u>									
4109 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last									
(b) DUE TO, OR AS A CONSEQUENCE OF									
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?		
							YES <input type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
			HOUR A.M. P.M. 19						
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE			CHIEF MEDICAL EXAMINER			22b. DATE SIGNED			
EXAMINER'S NAME (Type)			M.D. ASSISTANT MEDICAL EXAMINER			8-1968			
Philip A. Insley			DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			116 E. Main St. Salisbury, Md.			
ADDRESS (Street, city, town, or county)									
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or town) (County) (State)		
BURIAL			8/21/1968		FAIRMOUNT CEMETERY		FAIRMOUNT, MARYLAND		
24. FUNERAL DIRECTOR ADDRESS					25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE		
LEVIN R. WILSON PRINCESS ANNE, MD.					DATE AUG 22 1968		Charles Judge		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 12 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
12256 CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH		2b. HOUR		
WALLACE LINWOOD MATTHEWS						Month Day Year August 21 1968		6:20 P M		
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER 1 YEAR		
Male		White		June 4, 1912		56 YRS.		MONTHS DAYS HOURS MIN		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				
Maryland		USA				WICOMICO Md.				
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY		
Salisbury			Peninsula General Hospital			Carpenter		Building		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER	
Maryland			Wicomico		Salisbury		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		634 Decatur Avenue	
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME							
First Middle Last Elmer S. Matthews			First Middle Last Virginia Hales							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT (Daughter) Address R.D. 4					
No			218-12-1141		Mrs. Barbara Lee Evans, Salisbury, Maryland					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Myocardial Infarction 4 hrs DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) arteriosclerotic heart disease 4 YRS DUE TO, OR AS A CONSEQUENCE OF (c)									hrs	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) (OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 5-31, 1968, to 8-21, 1968, that (I) (we) last saw the deceased alive on 8-21, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death										
22b. SIGNATURE John T. Bulkeley M.D.					22c. DATE SIGNED August 22/1968					
22d. PHYSICIAN'S NAME (Type) Dr. John T. Bulkeley					22e. ADDRESS S. Salisbury Blvd., Salisbury, Maryland					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)				
Burial		August 24, 1968		Wicomico Memorial Park		Salisbury, Wicomico, Maryland				
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND					25a. REC'D BY REGISTRAR DATE AUG 26 1968		25b. REGISTRAR'S SIGNATURE John C. Judge			



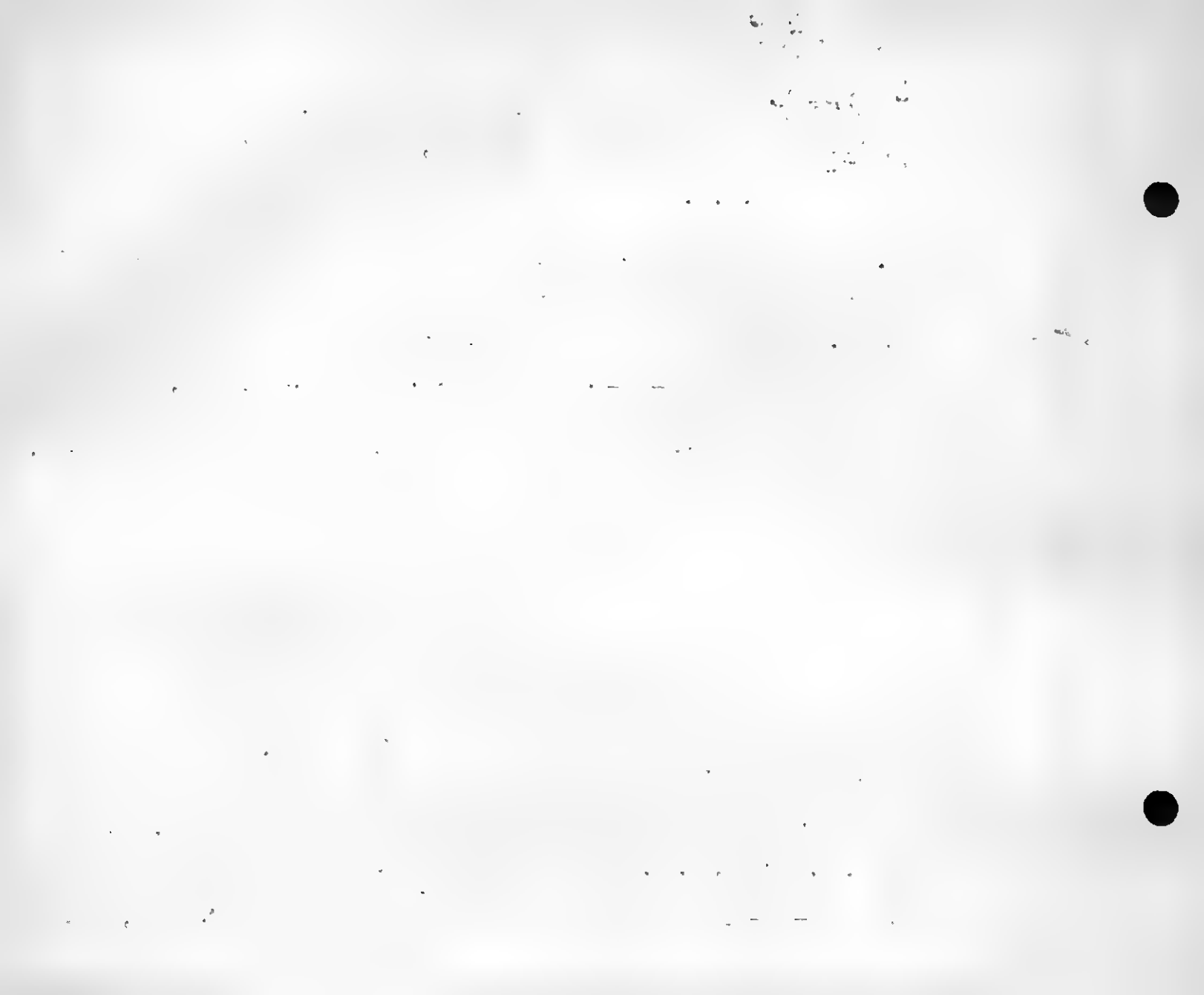
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
12257  
CERTIFICATE OF DEATH

1968

1 DECEASED-NAME (Type or print) First Middle Last <b>Patrick Henry McGee</b>			2a DATE OF DEATH Month Day Year <b>Aug. 25 1968</b>		2b HOUR <b>8 P. M.</b>
3 SEX <b>male</b>	4 RACE <b>white</b>	5 DATE OF BIRTH <b>May 16, 1891</b>		6 AGE (In years) <b>77</b> (day) YRS	IF UNDER YEAR MONTHS DAYS IF UNDER 24 HRS HOURS MIN
7a BIRTHPLACE (State or foreign country) <b>Virginia</b>	7b CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Wicomico</b> Md		
10. CITY OR TOWN OF DEATH <b>Salisbury</b>	11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Deer's Head State Hospital</b>		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired Gas Station Owner</b>		12b. KIND OF BUSINESS OR INDUSTRY
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>	13b COUNTY <b>Caroline</b>	13c CITY OR TOWN <b>Greensboro</b>	13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	13e STREET AND NUMBER <b>RFD #1</b>	
14 FATHER'S NAME First Middle Last <b>John W. Mc Gee</b>		15 MOTHER'S MAIDEN NAME First Middle Last <b>No Record</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b SOCIAL SECURITY NO <b>216-26-7499</b>	17. INFORMANT Address <b>Louise McGee Greensboro, Maryland</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Ca. of bladder with metastasis</b> <b>185X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>2 1/2 years.</b>					
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)	
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (At home, farm, street, factory) OFFICE BUILDING, ETC.		21f LOCATION Street or RFD No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>July 8, 1968</b> , to <b>Aug. 25, 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug. 25, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.					
22b SIGNATURE <b>W. H. Malve</b>		DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input checked="" type="checkbox"/>		22c DATE SIGNED <b>Aug. 26, 1968</b>	
22d PHYSICIAN'S NAME (Type) <b>L. V. Maldve, M. D.</b>		22e ADDRESS <b>Deer's Head State Hospital, Salisbury, Md.</b>			
23a BURIAL, CREMATION, REINTERMENT <b>Buried</b>	23b DATE <b>8-28-68</b>	23c NAME OF CEMETERY OR CREMATORY <b>Holy Cross</b>		23d LOCATION (City or Town) (County) (State) <b>Near Greensboro, Md.</b>	
24 FUNERAL DIRECTOR <b>G. E. Boucades Greensboro, Md.</b>		ADDRESS		25a REC'D BY REGISTRAR DATE <b>AUG 29 1968</b>	25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

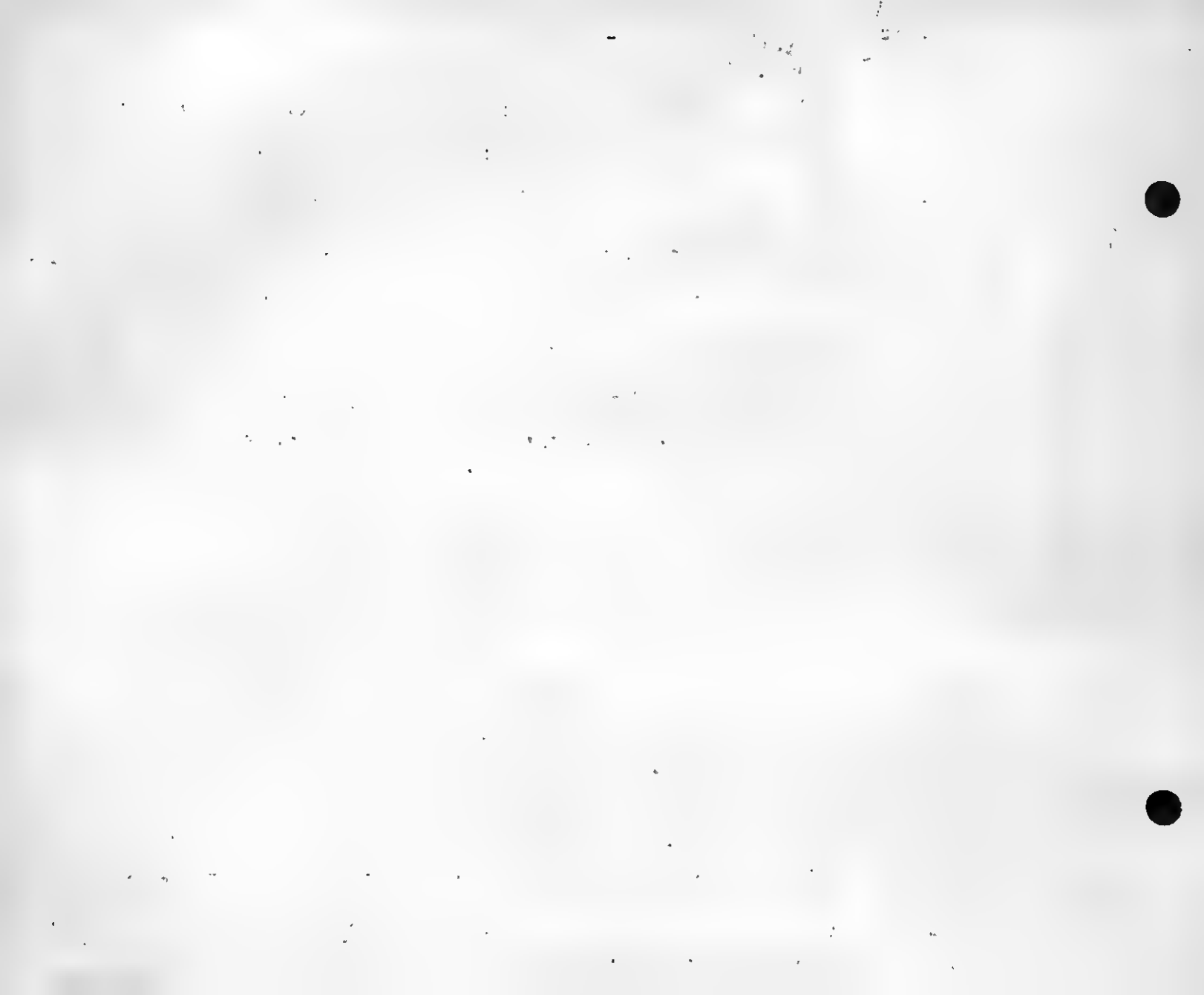
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.



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MARYLAND STATE DEPARTMENT OF HEALTH -DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
12258									
1 DECEASED-NAME (Type or print) First Middle Last MARION ROBERT MCINTYRE					2a. DATE OF DEATH Month Day Year August 24 1968			2b. HOUR M	
3 SEX Male		4 RACE White		5. DATE OF BIRTH March 10, 1914		6 AGE (In years lost birthday) 54 YRS		7 UNDER 1 YEAR MONTHS DAYS F UNDER 24 HRS HOURS MIN	
7a. BIRTHPLACE (State or foreign country) Maryland		7b. CITIZEN OF WHAT COUNTRY? USA		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH WICOMICO			
10. CITY OR TOWN OF DEATH Salisbury		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) Supervisor		12b. KIND OF BUSINESS OR INDUSTRY Food Processing			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE Maryland		13b. COUNTY Somerset		13c. CITY OR TOWN Eden		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Box 38	
14 FATHER'S NAME First Middle Last Elmer Raymond McIntyre				15 MOTHER'S M.A.DEN NAME First Middle Last Nora E. Twilley					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service) No		16b. SOCIAL SECURITY NO 218-05-8912		17 INFORMANT (Wife) Mrs. Myrtle L. McIntyre, Eden, Maryland		Address P.O. Box 38			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Carcinoma of lungs</u> DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH 1-2 yrs
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from 8:24, 1968, to 8:25, 1968, that (I) (we) last saw the deceased alive on 8:24, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>H. Briele</u>					DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED August 26/1968		
22d. PHYSICIAN'S NAME (Type) Dr. Henry A. Briele					22e. ADDRESS Medical Center, Salisbury, Maryland				
23a. B. RIAL, CREMATION, REMOVAL (Specify) Burial		23b. DATE August 26, 1968		23c. NAME OF CEMETERY OR CREMATORY Allen Church Cemetery		23d. LOCATION (City or Town) (County) (State) Allen, Maryland			
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND					25a. REC'D BY REGISTRAR DATE AUG 27 1968		25b. REGISTRAR'S SIGNATURE <u>J. Charles Judge</u>		





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
12259  
CERTIFICATE OF DEATH

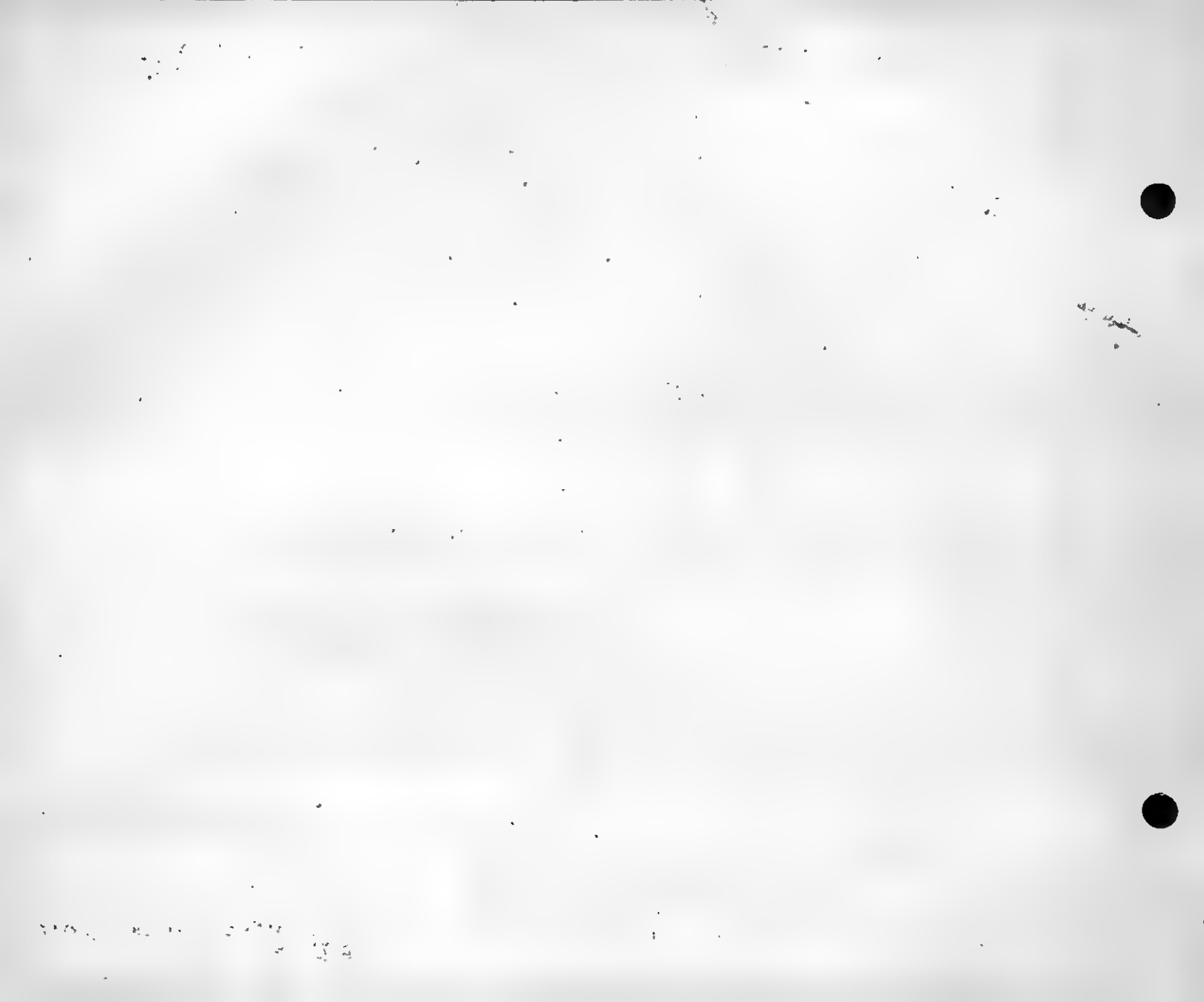
1. DECEASED NAME (Type or print)		First ALLAN	Middle LADD	Last MORGAN	2a. DATE OF DEATH Month Day Year August 16 1968		2b. HOUR 32 2 P M	
3 SEX MALE	4. RACE White		5. DATE OF BIRTH 8-16-68		6. AGE (In years lost birthday) 0 YRS.		IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN 5 43
7a. BIRTHPLACE (State or foreign country) Md		7b. CITIZEN OF WHAT COUNTRY? USA		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md.		
10. CITY OR TOWN OF DEATH Salisbury-Peninsula General Hospital		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) none		12b. KIND OF BUSINESS OR INDUSTRY ---		
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE Md		13b. COUNTY Wicomico		13c. CITY OR TOWN Salisbury		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER Johnson Rd Rty Hancock Trailer Park
14. FATHER'S NAME First Middle Last Richard Eugene Morgan III		15. MOTHER'S MAIDEN NAME First Middle Last Leona B Volkmer		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service) no				
16b. SOCIAL SECURITY NO. ----		17. INFORMANT (Father) R.D. 4 Address Hancock Trailer Park Mr. Richard Eugene Morgan III, Salisbury, Md						
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) Immaturity 900 gm 5-43/60 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. DUE TO, OR AS A CONSEQUENCE OF (b) DUE TO, OR AS A CONSEQUENCE OF (c)								
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) 776x								
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from 8-16-68, 19, to 8-16-68, 19, that (I) (we) last saw the deceased alive on 8-16-68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.								
22b. SIGNATURE Chester C. Collins M.D.				DEGREE MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 8-17-68		
22d. PHYSICIAN'S NAME (Type) Dr. Chester C. Collins				22e. ADDRESS Medical Center, Salisbury, Maryland				
23a. BURIAL, CREMATION, or other disposition Burial		23b. DATE Aug. 22, 1968		23c. NAME OF CEMETERY OR CREMATORY Wicomico Memorial Park		23d. LOCATION (City or Town) (County) (State) Salisbury, Wicomico, Maryland		
24. FUNERAL DIRECTOR HOLLOWAY & COMPANY, SALISBURY, MARYLAND				25a. REC'D BY REGISTRAR DATE AUG 23 1968		25b. REGISTRAR'S SIGNATURE Charles Judge		



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Item 18 Film 403 8-16-68 DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12260 CERTIFICATE OF DEATH											
1. DECEASED NAME (Type or print) First Middle Last NEWELL William PAYNE						2a. DATE OF DEATH Aug Month 3 Day 68 Year			2b. HOUR 8:00 P.M.		
3 SEX M		4 RACE W		5. DATE OF BIRTH 27 Feb 02		6. AGE (In years last birthday) 66 YRS		7. UNDER 1 YEAR MONTHS DAYS		7. UNDER 24 HRS HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) VA.		7b. CITIZEN OF WHAT COUNTRY? US		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md					
10. CITY OR TOWN OF DEATH SALISBURY			11. NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address) WIC MORSING HLY			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) MERCHANT			12b. KIND OF BUSINESS OR INDUSTRY RETAIL		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE MD			13b. COUNTY Wor		13c. CITY OR TOWN Pocomoke		13d. INSIDE CITY LIMITS YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER R.F.D. 2		
14. FATHER'S NAME First Middle Last William ? Payne				15. MOTHER'S MAIDEN NAME First Middle Last Betty ? Pichard							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown NO				16b. SOCIAL SECURITY NO. 215-26-5089		17. INFORMANT Address WIFE - CARRE P. SAME (WIFE)					
18. CAUSE OF DEATH (Enter any one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) PNEUMONIA 1.9 DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) ASCITES DUE TO, OR AS A CONSEQUENCE OF (c) CARCINOMATOSIS, Pancreas											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION 29 Dec 68		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)							
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State	
22a. I certify that (I) (this hospital) attended the deceased from 29 June, 1968, to 3 Aug, 1968, that (I) (we) last saw the deceased alive on 3 Aug, 1968, and that (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE Charles Bagley, M.D.						22c. DATE SIGNED 3 Aug 68		22d. PHYSICIAN'S NAME (Type) CHARLES BAGLEY, M.D.		22e. ADDRESS SALISBURY, MD	
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 8-6-1968		23c. NAME OF CEMETERY OR CREMATORY FIRST BAPTIST		23d. LOCATION (City or Town) (County) (State) Pocomoke - Wor. - MD.		24. FUNERAL DIRECTOR Robert H. Watson Pocomoke, MD.			
25a. REC'D BY REGISTRAR DATE AUG 7 1968				25b. REGISTRAR'S SIGNATURE Richard J. Young							



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
12265 CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH Month Day Year			2b HOUR
MERTIE IRENE GOLDER PHILLIPS						August 11 1968			9:20A M
3. SEX	4 RACE		5 DATE OF BIRTH			6 AGE (in years last birthday)		7 IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
Female	White		8/20/1889			78 YRS			
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Penna.		U. S. A.				WITCOMICO Md.			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY
Salisbury			Deer's Head State Hospital			Housework - own home			
13a USUAL RESIDENCE (Where deceased lived, if institut on. Residence before admission) STATE			13b COUNTY		13c CITY OR TOWN	13d INS. DE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
Maryland			Worchester		Cambridge			500 Elm Street	
14 FATHER'S NAME First Middle Last			15 MOTHER'S MAIDEN NAME First Middle Last						
Daniel Golder			Elizabeth Dollman						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO		17 INFORMANT Address				
No					Mrs Katherine Phillips, Cambridge				
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Bronchopneumonia</u>									3 days
DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <u>485 X</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) _____ (c) _____									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>Cerebral Thrombosis and Diabetes Mellitus</u>									
19a DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Nat wh. le <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <u>January 21, 1968</u> , to <u>August 11, 1968</u> , that (I) (we) last saw the deceased alive on <u>August 11, 1968</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE		22c. DATE SIGNED							
<u>W. Maldve</u>		8/12/68							
22d. PHYSICIAN'S NAME (Type)		22e ADDRESS							
L. V. Maldve, M. D.		Deer's Head State Hospital, Salisbury, Md							
23a. RITIAL CREMATION REMOVAL (Specify)		23b. DATE	23c. NAME OF CEMETERY OR CREMATORY			23d. LOCATION (City or Town) (County) (State)			
Burial		8/14/68	East New Market			East New Market, Dor. Md			
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE				
<u>Keith S. Thoroughly</u>		DATE AUG 15 1968			<u>Charles Judge</u>				



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### 12262 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF EST- DEATH MATED	Month	Day	Year	2b HOUR
ROBERT		LEE	PHILLIPS		<input checked="" type="checkbox"/> 8-22-68	19			4 P.M.
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS DAYS	IF UNDER 24 HRS HOURS MIN	2c DATE PRONOUNCED DEAD			2d HOUR
M	AA	9-3-15	52 YRS			Month	Day	Year	5 P.M.
7a BIRTHPLACE (State or foreign country)	7b CITIZEN OF WHAT COUNTRY?	8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9 COUNTY OF DEATH			Md.			
Md.	U.S.A.		Wicomico						
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		2b KIND OF BUSINESS OR INDUSTRY			
Salisbury		725 Westover Drive							
13a USUAL RESIDENCE (Where deceased lived, if admission) STATE		13b COUNTY	13c CITY OR TOWN	13d INSIDE CITY LIMITS?	13e STREET AND NUMBER				
Md.		Wicomico	Salisbury	YES <input type="checkbox"/> NO <input type="checkbox"/>	728 Westover Drive				
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last
Unknown					Hattie Brown				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS			
		259-14-8957		Josie Phillip		728 Westover Drive			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))								APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Metastatic carcinoma of liver								months	
1621 DUE TO, OR AS A CONSEQUENCE OF									
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last								(b) Carcinoma of lung	
DUE TO, OR AS A CONSEQUENCE OF								year	
(c)									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
1222 X									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?		20. AUTOPSY?					
7-25-68		Liver biopsy		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. P.M.		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
		19 P.M.							
21d INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County	State
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b DATE SIGNED	
EXAMINER'S NAME (Type)		Carl L. Royer, M.D.						Aug. 26, 1968	
109 Camden Ave., Salisbury, Md.		ADDRESS (Street, city, town, or county)							
23a BURIAL, CREMATION, REMOVAL (Specify)	23b DATE	23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town)		(County)		(State)	
Burial	8-27-68	Green Acres		Salisbury Wicomico		Md.			
24 FUNERAL DIRECTOR		ADDRESS		25a REC'D BY REG. STRAR		25b REGISTRAR'S SIGNATURE			
Jolley Funeral Home, Salisbury, Md.				DATE SEP 5 1968		Charles Judge			



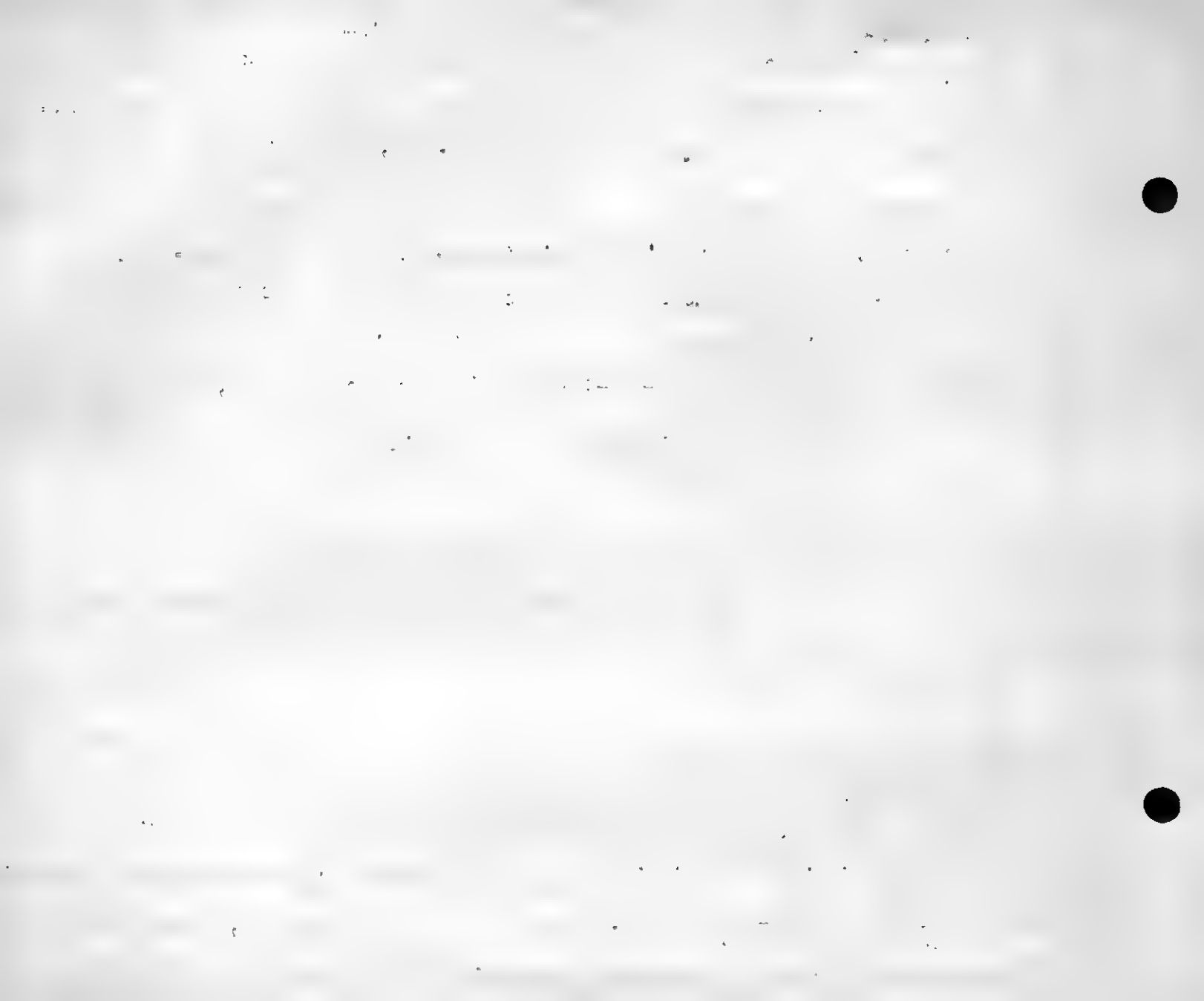


TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15 (4)  
304A REV. 1/68

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201														
12263														
CERTIFICATE OF DEATH														
1. DECEASED-NAME (Type or print)			First <b>FREDerick</b>		Middle <b>PINDER</b>		Last <b>PINDER</b>		2a. DATE OF DEATH 8 Month 24 Day 1968		2b. HOUR 4:45 P M			
3. SEX <b>Male</b>		4. RACE <b>White</b>			5. DATE OF BIRTH <b>Oct. 26, 1883</b>			6. AGE (In years last birthday) <b>84</b> YRS.		7. UNDER 1 YEAR MONTHS DAYS		8. UNDER 24 HRS HOURS MIN		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>Wisconsin</b> Md.					
10. CITY OR TOWN OF DEATH <b>Salisbury</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Deer's Head State Hosp.</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Retired Telephone Co.</b>			12b. KIND OF BUSINESS OR INDUSTRY					
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Caroline</b>			13c. CITY OR TOWN <b>Marydel</b>			13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>None</b>			
14. FATHER'S NAME First <b>William Pinder</b>			Middle <b>Pinder</b>			Last <b>Pinder</b>			15. MOTHER'S MAIDEN NAME First <b>Clara Jane Hursey</b>			Middle <b>Hursey</b>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>			16b. SOCIAL SECURITY NO. <b>162-03-1446</b>			17. INFORMANT <b>Emily Pinder Marydel, Maryland</b>			Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Broncogenic Ca. left lung</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>1621</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1 year</b>				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>10x1</b>														
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?					
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State								
22a. I certify that (I) (this hospital) attended the deceased from <b>4/24</b> , 19 <b>68</b> , to <b>8/24</b> , 19 <b>68</b> , that (I) (we) lost saw the deceased alive on <b>8/24/68</b> 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.														
22b. SIGNATURE <b>L. V. Maldve, M. D.</b>			22c. DATE SIGNED <b>8/26/68</b>			22d. ADDRESS <b>Deer's Head State Hospital; Salisbury, Md.</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>8-28-68</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Mt. Olive</b>			23d. LOCATION (City or Town) (County) (State) <b>Sandtown, Delaware</b>					
24. FUNERAL DIRECTOR <b>J. E. Boudreau, Greensboro, Md.</b>			25a. REC'D BY REGISTRAR DATE <b>AUG 28 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>								



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. When please remove carbon papers, and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH									
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
Film 03 8/16/68 km <b>CERTIFICATE OF DEATH</b> 12264									
1 DECEASED NAME (Type or print) <b>ELIZO</b>			First Middle Last <b>Powell</b>			2a. DATE OF DEATH Month Day Year <b>August 4 1968</b>		2b. HOUR <b>6:25</b> M	
3 SEX <b>Female</b>		4 RACE <b>Negro</b>		5 DATE OF BIRTH <b>10/15/1884</b>		6 AGE (in years last birthday) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN	
7a BIRTHPLACE (State or foreign country) <b>Worcester</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b> Md.			
10 CITY OR TOWN OF DEATH <b>Salisbury - Peninsula</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>General Hospital</b>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>Domestic</b>		12b KIND OF BUSINESS OR INDUSTRY <b>none</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution Res. degree before admission) STATE <b>md</b>		13b COUNTY <b>Worcester</b>		13c CITY OR TOWN <b>Berlin</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER	
14. FATHER'S NAME First Middle Last <b>ur</b>			15 MOTHER'S MAIDEN NAME First Middle Last <b>unknown</b>						
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, NO, or UNKNOWN <b>NO</b> (If yes give war or dates of service)			16b SOCIAL SECURITY NO <b>214-12-5598</b>		17 INFORMANT <b>R. White</b>		Address		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Metastatic Carcinoma</b> <b>1991</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>1992</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, natly medical examiner)		21b TIME OF INJURY HOUR AM Month Day Year PM 19			21c HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)				
21d INJURY OCCURRED While <input type="checkbox"/> Nat while <input type="checkbox"/> at work at work		21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)			21f LOCATION Street or R.F.D. No.		City or Town		County State
22a. I certify that (I) (this hospital) attended the deceased from <b>7-18</b> , 1968, to <b>8-4</b> , 1968, that (I) (we) last saw the deceased alive on <b>8-4</b> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death.									
22b SIGNATURE <b>David J. Gilmore</b> DEGREE					ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c DATE SIGNED <b>8-8-68</b>		
22d PHYSICIAN'S NAME (Type) <b>DAVID J. GILMORE</b>					22e ADDRESS <b>MEDICAL CENTER, SALISBURY, MD</b>				
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE <b>8-7-68</b>		23c NAME OF CEMETERY OR CREMATORY <b>New Bethel Cem</b>		23d LOCATION (City or Town) (County) (State) <b>Berlin Wicomico Md</b>			
24 FUNERAL DIRECTOR <b>Brokers West</b> ADDRESS					25a REC'D BY REGISTRAR DATE <b>AUG 13 1968</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or print) <b>John</b>			Middle <b>S.</b>			Last <b>Price</b>		2a. DATE OF DEATH Month <b>August</b> Day <b>23</b> Year <b>1968</b>		2b. HOUR <b>9P.M.</b>
3 SEX <b>Male</b>		4. RACE <b>White</b>		5. DATE OF BIRTH <b>FEB. 5-1876</b>		6 AGE (In years last birthday) <b>92</b> YRS.		IF UNDER 1 YEAR MONTHS <b>—</b> DAYS <b>—</b>		IF UNDER 24 HRS HOURS <b>—</b> MIN <b>—</b>
7a BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b>		Md.		
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Deer's Head State Hospital</b>		12a. USUA. OCCUPATION (Kind of work done during most of working life, even if retired.) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>WATERMAN</b>				
13a. USUA. RESIDENCE (Where deceased lived, if institution- Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>SOMERSET</b>		13c. CITY OR TOWN <b>CHANCE</b>		13d. INSIDE CITY (LMA 157) YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>MAIN ROAD</b>		
14. FATHER'S NAME First <b>SEVERN</b> Middle <b>PRICE</b> Last <b>WHITE</b>			15. MOTHER'S MAIDEN NAME First <b>CHARLOTTE</b> Middle <b>WHITE</b> Last <b>WHITE</b>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes, give war or dates of service) <b>No</b>			16b. SOCIAL SECURITY NO. <b>UNKNOWN</b>		17. INFORMANT <b>Mrs. HOLMAN WATSON - SALISBURY, MD</b>			Address <b>SANDY HILL ROAD</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY- <b>4109</b> IMMEDIATE CAUSE (a) <b>Coronary Occlusion</b>										—
DUE TO, OR AS A CONSEQUENCE OF (b) <b>Arteriosclerotic Cardiovascular Disease</b>										Years
DUE TO, OR AS A CONSEQUENCE OF (c)										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>7201</b>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No.		City or Town		County		State
22a. I certify that (I) (this hospital) attended the deceased from <b>3/13/68</b> , 19__, to <b>8/23/68</b> , 19__, that (I) (we) last saw the deceased alive on <b>8/23/68</b> , 19__, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.										
22b. SIGNATURE <b>L. Maldve, M.D.</b>		DEGREE		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>8/24/68</b>				
22d. PHYSICIAN'S NAME (Type) <b>L. Maldve, M.D.</b>		22e. ADDRESS <b>P.O. Box 2018, Salisbury, Md. - 21801</b>								
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>8-26-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Rock Creek</b>		23d. LOCATION (City or Town) <b>CHANCE</b>		County <b>Som</b>		State <b>MD</b>
24. FUNERAL DIRECTOR <b>Leroy Webster Princess Anne Md</b>				25a. REC'D BY REGISTRAR <b>DATE AUG 27 1968</b>		25b. REGISTRAR'S SIGNATURE <b>J. Charles Judge</b>				



**FOR STATE  
HEALTH DEPT.**

**TO DEPUTY MEDICAL EXAMINER:** This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form 5 may be retained for your files.

**TO FUNERAL DIRECTOR:** Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH <b>12266</b>											
1 DECEASED NAME (Type or Print) <b>Addie M. PURNELL</b>						2a DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> <b>8 20 1968</b>			2b HOUR M <input type="checkbox"/> AM <input type="checkbox"/>		
3 SEX <b>F</b>		4 RACE <b>W</b>		5 DATE OF BIRTH <b>FEB. 28, 1896</b>		6 AGE (In years last birthday) <b>72 YRS</b>		7 IF UNDER 24 YEARS MONTHS <input type="checkbox"/> DAYS <input type="checkbox"/> HOURS <input type="checkbox"/> MIN <input type="checkbox"/>		2c DATE PRONOUNCED DEAD Month <input type="checkbox"/> Day <input type="checkbox"/> Year <input type="checkbox"/> <b>AUG 20 1968</b>	
7a BIRTHPLACE (State or foreign country) <b>BERLIN MD</b>		7b CITIZEN OF WHAT COUNTRY? <b>USA.</b>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH <b>Wicomico</b>					
10 CITY OR TOWN OF DEATH <b>SALISBURY</b>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>PEN. GENERAL</b>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>HOUSEWIFE</b>		12b KIND OF BUSINESS OR INDUSTRY <b>HOME</b>	
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <input checked="" type="checkbox"/> COUNTY <input checked="" type="checkbox"/> <b>MARYLAND WOR.</b>				13b CITY OR TOWN <b>BERLIN</b>		13c INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <b>BRIDDLEROW R.D.</b>			
14 FATHER'S NAME First Middle Last <b>GEORGE FASSETT</b>						15 MOTHER'S MAIDEN NAME First Middle Last <b>SUSAN SMACK</b>					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, at unknown) <b>NO</b>				16b SOCIAL SECURITY NO <b>220-03-6885A</b>		17 INFORMANT ADDRESS <b>Mr. W.H. PURNELL BERLIN MD</b>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Coronary thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <b>Diabetes</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Arteriosclerotic heart disease</b>										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>Diabetes - Arteriosclerotic heart disease</b>											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20 AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR A.M. <input type="checkbox"/> P.M. <input checked="" type="checkbox"/> <b>19</b>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f LOCATION Street or R.F.D. No		City or Town		County		State	
22a I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> , Inspection <input type="checkbox"/> , Inquiry <input type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <i>Philip A. Insley</i>		EXAMINER'S NAME (Type) <b>Philip A. Insley</b>		M.D.		CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
						ADDRESS (Street, city, town, or county)		22b. DATE SIGNED <b>8/20/68</b>		Salisbury, Md.	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE <b>8/24/68</b>		23c NAME OF CEMETERY OR CREMATORY <b>EVERGREEN</b>		23d LOCATION (City or Town) (County) (State) <b>BERLIN MD</b>		25a REC'D BY REG. STRAR <b>AUG 27 1968</b>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>	
24 FUNERAL DIRECTOR <i>Anna A. Burboze</i>											





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
12267										
CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print) <i>Herbert</i>			First Middle Last <i>Purnell</i>			2a. DATE OF DEATH Month Day Year <i>8 7 68</i>		2b. HOUR <i>8:45 A M</i>		
3 SEX <i>Male</i>		4. RACE <i>Negro</i>		5. DATE OF BIRTH <i>June 28 1909</i>		6. AGE (In years last birthday) <i>59</i> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a. BIRTHPLACE (State or foreign country) <i>NEWARK</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>		8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Wicomico</i> Md.				
10. CITY OR TOWN OF DEATH <i>Salisbury - Peninsula General Hospital</i>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life even if retired) <i>Chef Cook</i>		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>MARYLAND</i>			13b. COUNTY <i>WORCESTER</i>		13c. CITY OR TOWN <i>NEWARK</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <i>Box 73</i>	
14. FATHER'S NAME First Middle Last <i>Edgar Purnell</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Harriett Porter</i>							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO <i>214-28-344</i>		17. INFORMANT Address <i>Alie Purnell Box 73 Newark, Md.</i>					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b) and (c). PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Coronary Artery Thrombosis</i> 4109 DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.										
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>2201</i>										
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <i>7-30-68</i> , 19 <i>68</i> , to <i>8-1-</i> , 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>19</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (d d) (did not) view the body after death.										
22b. SIGNATURE <i>David J. Gilmore</i>					DEGREE ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED			
22d. PHYSICIAN'S NAME (Type) <i>David J. Gilmore</i>					22e. ADDRESS <i>Medical Center, Salisbury, Md.</i>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>BURIAL</i>		23b. DATE <i>8-5-68</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Cedar Chapel</i>		23d. LOCATION (City or Town) (County) (State) <i>Newark Worcester, Md.</i>				
24. FUNERAL DIRECTOR <i>Gonzalez B. Jolley</i>					25a. REC'D BY REGISTRAR DATE <i>AUG 8 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>			

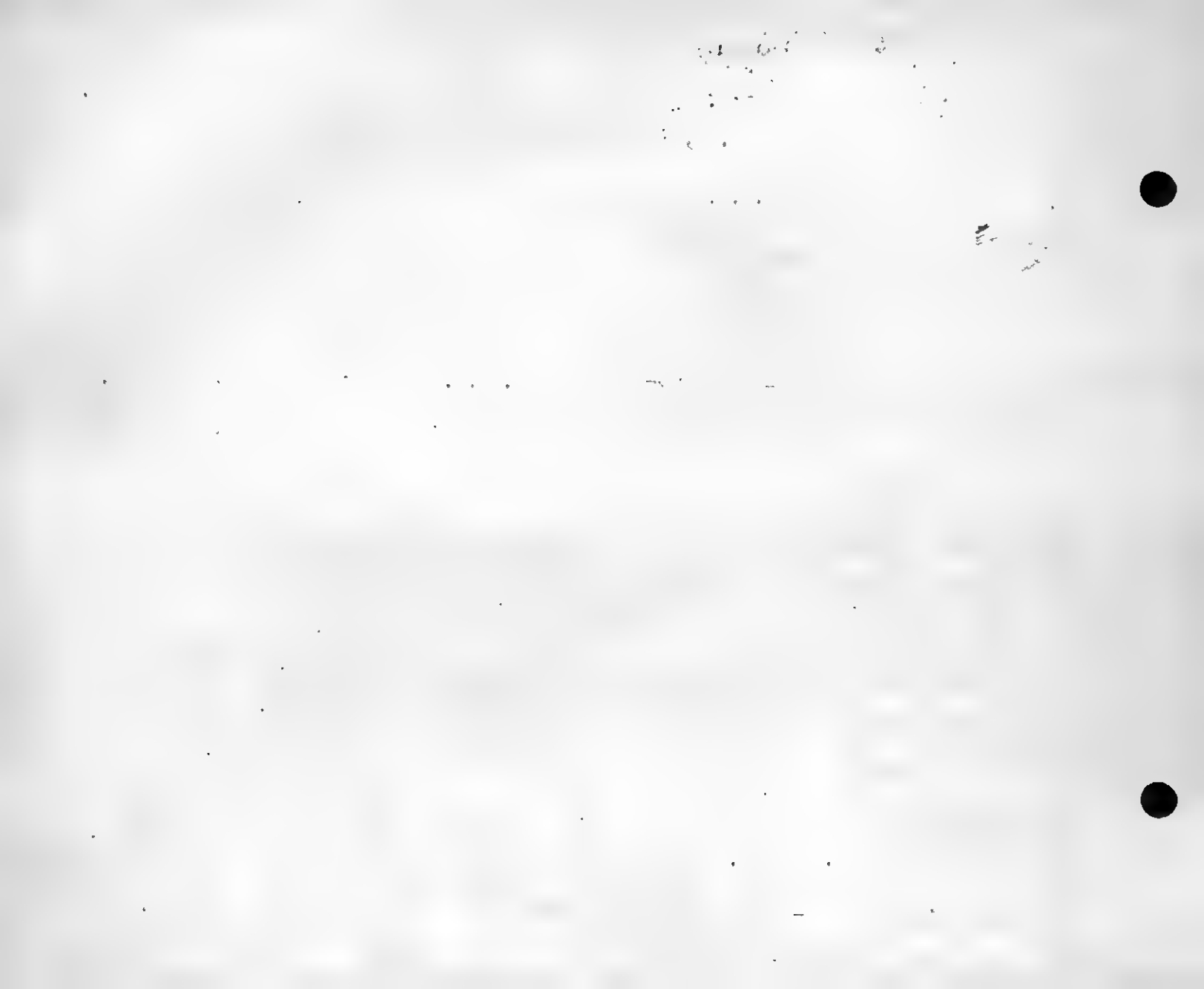


**FOR STATE  
HEALTH DEPT.**

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1 DECEASED NAME (Type or Print)			First Middle Last			2a DATE KNOWN OF DEATH		2b HOUR		
JULIA JONES RANDOLPH						Month 8 Day 31 Year 1968		10:10		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (in years last birthday)	7 UNDER 1 YEAR	IF UNDER 24 HRS	2c DATE PRONOUNCED DEAD		2d HOUR		
Female	White	Dec. 16, 1884	82 YRS	MONTHS	DAYS	Month 8 Day 31 Year 1968		10:10		
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9 COUNTY OF DEATH				
Alabama		U.S.A.				Wicomico		Md		
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)				12a USJA. OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Salisbury		Peninsula General Hospital				Unknown		Unknown		
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE			13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS?		13e. STREET AND NUMBER	
Alabama			Hale		Greensboro		YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		805 Oots	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME							
John Randolph			Kate Jones							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO		17 INFORMANT ADDRESS					
no			900-00-3522		Mr. W.S. Cook Box 386 Demopolis, Ala.					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1 DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Arterio Sclerotic Heart Disease</u>									Years	
DUE TO, OR AS A CONSEQUENCE OF										
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last <u>4200</u>										
DUE TO, OR AS A CONSEQUENCE OF										
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)										
<u>Fracture of Left Hip</u>										
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?				
8-25-68			Fx of Left Hip			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>				
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH			21b TIME OF INJURY Month, Day Year			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)				
			11 PM 8-22-1968			Knocked down on Street by Child				
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input checked="" type="checkbox"/>			21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or RFD No City or Town County State				
			Street			Main St. Salisbury Wicomico Md				
22a I certify that I took charge of the remains described above, held on death resulted from									Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Injury <input checked="" type="checkbox"/> and in my opinion	
Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE			EXAMINER'S NAME (Type)			22b. DATE SIGNED				
<u>Earl L. Royer</u>			Dr. Earl L. Royer			8-31-1968				
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial			9-3-1968		Old Greensboro Cemetery		Greensboro, Hale. Alabama			
24 FUNERAL DIRECTOR ADDRESS					25a REC'D BY REG. STRAR		25b REGISTRAR'S SIGNATURE			
Hill Funeral Home Salisbury, Maryland					DATE SEP 3 1968		<u>Charles Judge</u>			



# MARYLAND STATE DEPARTMENT OF HEALTH

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

Item 1 Film G403 86160 KR

## CERTIFICATE OF DEATH

12269

279

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

1. PLACE OF DEATH a. COUNTY <u>Wicomico</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived, if institution. Res. den. before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>Wicomico</u>	
b. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>Salisbury</u>		c. CITY OR TOWN (if outside corporate limits, write RURAL and give nearest town) <u>SALISBURY MARYLAND</u>	
d. NAME OF HOSPITAL OR INSTITUTION (if not in hospital, give street address) <u>675 West Main Street</u>		d. STREET ADDRESS <u>675 West Main St.</u>	
3. NAME OF DECEASED (Type or print) First <u>NATHAN</u> Middle <u>Wesley</u> Last <u>Reed</u>		4. DATE OF DEATH Month <u>8</u> Day <u>5</u> Year <u>1968</u>	
5. SEX <u>M</u>	6. COLOR OR RACE <u>N</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>APR 12 1884</u>
9. AGE (In years last birthday) <u>84</u> yrs		10. IF UNDER 1 YEAR Months Days Hours Min	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired)		10b. KIND OF BUSINESS OR INDUSTRY	
11. BIRTHPLACE (County & State, or foreign country) <u>Chance</u>		12. CITIZEN OF WHAT COUNTRY? <u>U.S.A.</u>	
13. FATHER'S NAME <u>NATHAN Wesley Reed</u>		14. MOTHER'S MAIDEN NAME <u>SARAH Armstrong</u>	
15. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown) (If yes give war or dates of service)		16. SOCIAL SECURITY NO.	
17. INFORMANT <u>MARY Reed</u>		Address <u>675 West Main St. SALISBURY, MD.</u>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Coronary Occlusion</u> 411 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) <u>Atherosclerosis</u> DUE TO (c) <u>Endarteritis</u>		INTERVAL BETWEEN ONSET AND DEATH <u>1 day</u>	
PART II OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>4201</u>		19. WAS ALTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED (Enter nature of injury in Part I or Part II of item 18)	
20c. TIME OF INJURY Month, Day, Year Hour a.m. p.m. <u>19</u>	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not While at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that (I) (this hospital) attended the deceased from <u>1 June 1967</u> to <u>5 Aug 1968</u> , that (I) (we) last saw the deceased alive on <u>5 Aug 1968</u> , and that death occurred at <u>12N</u> , from causes and at the date stated above.			
22a. SIGNATURE <u>E. A. Parnell</u>		22b. DATE SIGNED <u>13 Aug 68</u>	
22c. PHYSICIAN'S NAME (Type) <u>E. A. Parnell MD</u>		22d. ADDRESS <u>672 W Main, Salisbury, Md</u>	
23a. BURIAL, CREMATION, REMOVAL (Specify) <u>Burial</u>	23b. DATE THEREOF <u>8-10-68</u>	23c. NAME OF CEMETERY OR CREMATORY <u>Green Acres Mem. Pk.</u>	23d. LOCATION (City or Town) (County) (State) <u>Salisbury Wico Md.</u>
24. FUNERAL DIRECTOR <u>Louetta B Jolley</u>		25a. REC'D BY REGISTRAR <u>James Judge</u>	
25b. REGISTRAR'S SIGNATURE <u>James Judge</u>		DATE <u>AUG 16 1968</u>	



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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
12270 CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or print)		First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR 1:28	
Elwood		-		Ruark				August 22 1968			
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER MONTHS		IF UNDER 24 HRS. MIN.	
male		white		Jan. 12, 1897		71 YRS.					
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.	
Maryland		U.S.A.				Wicomico					
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY					
Salisbury		Pine Bluff State Hospital		Carpenter		-					
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER			
Maryland		Wicomico		Salisbury				411 Race Street			
14. FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Elijah		-		Ruark				Esther		- Adkins	
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		Address					
No		-		220-12-1350		Pine Bluff State Hospital					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Carcinoma of lung										unknown	
1621 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.											
DUE TO, OR AS A CONSEQUENCE OF											
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)											
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? yes			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18)							
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21b. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21c. LOCATION Street or R.F.D. No City or Town County State							
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from Aug. 14, 1968, to Aug. 22, 1968, that <input checked="" type="checkbox"/> (we) last saw the deceased alive on Aug. 22, 1968, and that <input checked="" type="checkbox"/> (our) opinion of death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) (did) (did not) view the body after death.											
22b. SIGNATURE		E. P. Ritchings				DEGREE		ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input checked="" type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED Aug. 22, 1968	
22d. PHYSICIAN'S NAME (Type)		E. P. Ritchings, M.D.				22e. ADDRESS		Pine Bluff State Hospital			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)					
Burial		8-25-1968		Bethel Meth. Ch. Cem.		Walston Wicomico Md.					
24. FUNERAL DIRECTOR		Thomas F. Wallace				25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
		Salisbury, Md.				DATE AUG 26 1968		J. Charles Jones			





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12272

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <b>MAGGIE</b>			First Middle Last <b>BELLE RUARK</b>			2a. DATE OF DEATH Month <b>August</b> Day <b>12</b> Year <b>1968</b>			2b. HOUR <b>M</b>		
3. SEX <b>Female</b>			4 RACE <b>White</b>			5. DATE OF BIRTH <b>September 24, 1902</b>			6. AGE (In years last birthday) <b>65</b> YRS		
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>			7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>			8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH <b>WICOMICO</b>		
10. CITY OR TOWN OF DEATH <b>Salisbury</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>216 E. Vine Street</b>			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Seamstress</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>Shirt Factory</b>		
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <b>Maryland</b>			13b. COUNTY <b>Wicomico</b>			13c. CITY OR TOWN <b>Salisbury</b>			13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
13e. STREET AND NUMBER <b>216 E. Vine Street</b>			14. FATHER'S NAME First <b>Lee</b> Middle <b>Ruark</b> Last <b>Janie</b>			15. MOTHER'S MAIDEN NAME First <b>Janie</b> Middle <b>Lowe</b> Last <b>Lowe</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <b>No</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.			17. INFORMANT (Nephew) <b>Mr. Robert McAllister, Salisbury, Maryland</b>			Address <b>R.D. 4</b>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral hemorrhage</b> 4019 DUE TO, OR AS A CONSEQUENCE OF <b>Arteriosclerotic cerebral vasc. Disease</b> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>Discrete</b> (c)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>1/2 hr</b>		
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>231</b>											
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTR BUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No. City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <b>Mar</b> , 1968, to <b>Aug 12</b> , 1968, that (I) (we) last saw the deceased alive on <b>Aug 2</b> , 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.											
22b. SIGNATURE <b>Alberta Polin MD</b>			22c. DATE SIGNED <b>August 15/1968</b>			22d. PHYSICIAN'S NAME (Type) <b>Dr. Alberta Polin</b>			22e. ADDRESS <b>707 Camden Ave., Salisbury, Maryland</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>			23b. DATE <b>August 16, 1968</b>			23c. NAME OF CEMETERY OR CREMATORY <b>Wicomico Memorial Park</b>			23d. LOCATION (City or Town) (County) (State) <b>Salisbury, Wicomico, Maryland</b>		
24. FUNERAL DIRECTOR <b>HOLLOWAY &amp; COMPANY, SALISBURY, MARYLAND</b>			25a. RECD BY REGISTRAR <b>AUG 19 1968</b>			25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>					

MEDICAL CERTIFICATION



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
12272 CERTIFICATE OF DEATH

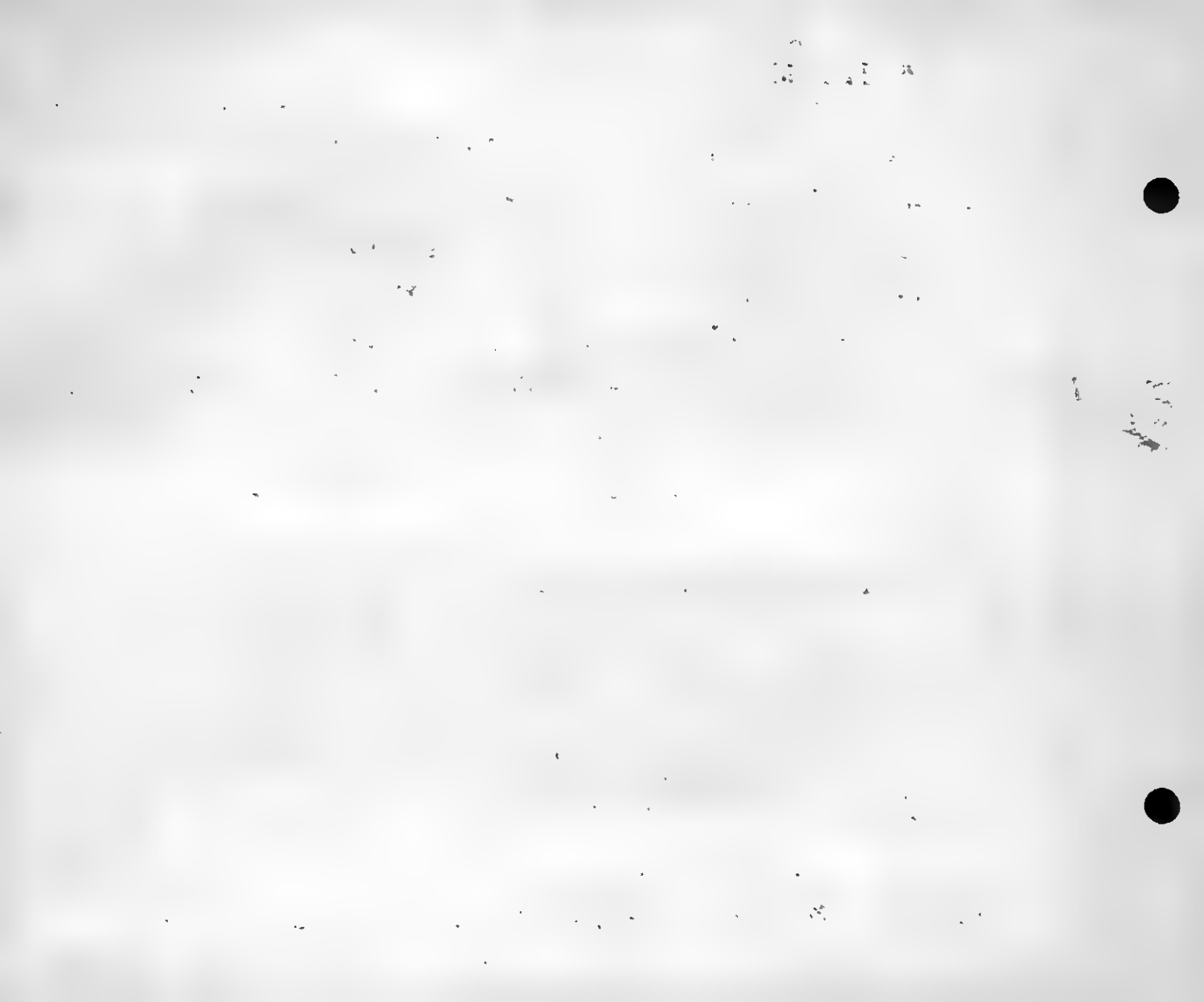
1. DECEASED-NAME (Type or print) <b>VERONICA</b>		First Middle Last <b>RUSEK</b>		2a. DATE OF DEATH Month Day Year <b>AUGUST 30 1968</b>		2b. HOUR <b>2 P.</b>	
3. SEX <b>FEMALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>AUG. 5 - 1892</b>		6. AGE (in years last birthday) <b>76</b> YRS.	
7a. BIRTH-PLACE (State or foreign country) <b>POLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b>	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Peninsula General Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <b>RETIRED</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>HOUSEHOLD</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution; Residence before admission) <b>PENN.</b>		13b. COUNTY <b>LACKAWANNA</b>		13c. CITY OR TOWN <b>DICKSON</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
14. FATHER'S NAME First Middle Last <b>JOSEPH KOWNACKI</b>		15. MOTHER'S MAIDEN NAME First Middle Last <b>UNKNOWN</b>		13e. STREET AND NUMBER <b>907 ALBERT STREET</b>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give dates of service) <b>NO</b>		16b. SOCIAL SECURITY NO <b>UNKNOWN</b>		17. INFORMANT <b>STELLA WEBSTER CHANCE</b>		Address <b>MARYLAND</b>	
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Carcinoma of Thyroid</b> <b>175 X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____						APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <b>8-07</b> , 19 <b>68</b> , to <b>8-30</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8-30</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>W. Webster Chance</b>				DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>8-30-68</b>	
22d. PHYSICIAN'S NAME (Type) <b>Leroy Webster</b>				22e. ADDRESS <b>Princess Anne, Md.</b>			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>9/3/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>CEMETERY ST. MARYS CATHOLIC</b>		23d. LOCATION (City or Town) (County) (State) <b>DICKSON CITY LACKAWANNA</b>	
24. FUNERAL DIRECTOR <b>Leroy Webster</b>				25a. RECD BY REGISTRAR <b>SEP 4 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (Their people remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.)

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
12273									
CERTIFICATE OF DEATH									
1. DECEASED NAME (Type or print)			First Middle Last			2a. DATE OF DEATH Month Day Year		2b. HOUR	
MARY			R. SATCHELL			August 12 1968		8:15AM	
3. SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS DAYS	
Female		White		2/8/1877		41 YRS			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH		12b. KIND OF BUSINESS OR INDUSTRY	
DELAWARE		USA				WICOMICO		Md	
10. CITY OR TOWN OF DEATH			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			
Salisbury			Deer's Head State Hospital			HOUSEWORK			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission). STATE			13b. CITY OR TOWN		13c. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER		
Maryland			Cordova						
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
—			GETSHALL			UNKNOWN			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If yes give war or dates of service)			16b. SOCIAL SECURITY NO.		17. INFORMANT Address				
No			217-03-5992		MRS. VIRGINIA SATCHELL, EASTON, MD.				
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Congestive heart failure</u> <u>4129</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardiovascular disease.</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u></u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>3 days</u>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <u>4221 Cerebral thrombosis - 4 years.</u>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> of work of work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (X) (this hospital) attended the deceased from <u>September 21 19 64</u> , to <u>August 12 19 68</u> , that (A) (we) lost saw the deceased alive on <u>August 12 19 68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (did not) view the body after death									
22b. SIGNATURE <u>A. C. Mitchell, M. D.</u>		22c. DATE SIGNED <u>8/12/68</u>		22d. PHYSICIAN'S NAME (Type) <u>A. C. Mitchell, M. D.</u>					
				22e. ADDRESS <u>Deer's Head State Hospital, Salisbury,</u>					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)			
BURIAL		8/16/1968		SPRING HILL		EASTON, MD			
24. FUNERAL DIRECTOR <u>MAURICE E. NEWMAN SON, EASTON, MD.</u>				25a. REC'D BY REGISTRAR DATE <u>AUG 14 1968</u>		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>			



FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File page 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

VR A15ME (5)  
10M REV 1/68

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12274 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										22884	
1 DECEASED NAME (Type or Print)		First		Middle		Last		2a DATE KNOWN OF DEATH		2b HOUR	
BERNARD		SCURRY						Month 8 Day 4 Year 1968		5 A M	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS		2c DATE PRONOUNCED DEAD		2d HOUR	
M	AA	6-5-68	YRS 2 MONTHS 0 DAYS	HOURS 0 MIN				Month 8 Day 4 Year 1968		7 A M	
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH				Md.	
Md		U.S.A				Wicomico					
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY					
Salisbury		Peninsula General		none		none					
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
Md.		Wicomico		Salisbury				W.F. Allen Labor Camp			
14 FATHER'S NAME		First		Middle		Last		15. MOTHER'S MAIDEN NAME		First Middle Last	
Arthur Scurry								Irene Daniel			
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS					
none		none		Arthur Scurry							
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>Broncho pneumonia</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>485 X</u>											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>485 X</u>											
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>				21b TIME OF INJURY Month, Day Year HOUR A.M. P.M. 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>				21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)				21f LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>											
ACTUAL SIGNATURE <u>Earl L. Royer, M.D.</u>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				22b. DATE SIGNED <u>Aug. 5, 1968</u>			
EXAMINER'S NAME (Type) <u>409 Camden Ave., Salisbury, Md</u>				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>				ADDRESS (Street, city, town, or county)			
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)					
Burial		8-6-68		Lawson Acres		Salisbury Wicomico					
24 FUNERAL DIRECTOR				ADDRESS				25a. REC'D BY REGISTRAR		25b REGISTRAR'S SIGNATURE	
Booker West Funeral Home, Salisbury, Md								DATE <u>AUG 13 1968</u>		<u>Michael J. Judge</u>	





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12275

CERTIFICATE OF DEATH

1968

1. DECEASED NAME (Type or print) <b>GORDY P. SHORES</b>			2a. DATE OF DEATH Month <b>AUGUST</b> Day <b>29</b> Year <b>1968</b>			2b. HOUR <b>6 A M</b>						
3. SEX <b>MALE</b>		4. RACE <b>WHITE</b>		5. DATE OF BIRTH <b>5-30-1916</b>		6. AGE (In years last birthday) <b>52</b> YRS.		IF UNDER 1 YEAR MONTHS <b>—</b> DAYS <b>—</b> HOURS <b>—</b> MIN <b>—</b>		IF UNDER 24 HRS. HOURS <b>—</b> MIN <b>—</b>		
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b> Md.						
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Peninsula General Hospital</b>				12a. USUAL OCCUPATION (Kind of work done during most of waking life, even if retired.) <b>LABORER</b>			12b. KIND OF BUSINESS OR INDUSTRY <b>SHIPYARD</b>			
13a. USUAL RESIDENCE (Where deceased lived, if institution, Residence before admission) STATE <b>MARYLAND</b>		13b. COUNTY <b>Wicomico</b>		13c. CITY OR TOWN <b>SALISBURY</b>		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>115 E. William ST.</b>				
14. FATHER'S NAME First <b>ARCHIE</b> Middle <b>SHORES</b> Last <b>MINNIE</b>			15. MOTHER'S MAIDEN NAME First <b>MINNIE</b> Middle <b>PARKS</b> Last <b>PARKS</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>NO</b> (If yes give war or dates of service)			16b. SOCIAL SECURITY NO. <b>219-05-3951</b>			17. INFORMANT <b>Mrs. Minnie Parks</b>			Address <b>21801 Salisbury MD</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <b>Valvulus - in a child for pleurisy due</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Physical condition very poor due</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Diagnosis of pleurisy, pneumonia, and pulmonary edema</b> PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Pneumonia, partial of throat which made feeding difficult</b>											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)								
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION - Street or RFD No. City or Town County State <b>Peninsula General Hospital Salisbury Wicomico Md</b>								
22a. I certify that (I) (this hospital) attended the deceased from <b>8/29/68</b> , 19 <b>1968</b> , to <b>8/29/68</b> , 19 <b>1968</b> , that (I) (we) lost saw the deceased alive on <b>8/29/68</b> , 19 <b>1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.												
22b. SIGNATURE <b>Corrie Hearin M.D.</b>						22c. DATE SIGNED <b>9/1/68</b>						
22d. PHYSICIAN'S NAME (Type) <b>CARRIE HEARIN M.D.</b>						22e. ADDRESS <b>226 W. Division St Salisbury</b>						
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>		23b. DATE <b>8-31-68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>ROCK CREEK CEMETERY</b>			23d. LOCATION (City or Town) (County) (State) <b>CHANCE SAN MD</b>					
24. FUNERAL DIRECTOR <b>Leroy Webster Priester</b>						25a. REC'D BY REGISTRAR <b>SEP 6 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>				



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
12276 CERTIFICATE OF DEATH									
1 DECEASED-NAME (Type or print)			First Middle Last			2a. DATE OF DEATH			2b HOUR
Carrie E. Smith						Month 8 Day 18 Year 1968			7:45 P.
3 SEX		4. RACE		5. DATE OF BIRTH		6. AGE (In years last birthday)		7. IF UNDER YEAR MONTHS DAYS HOURS MIN.	
Female		White		JAN. 17, 1880		88 YRS.			
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
		USA				Wilcomico Md			
10 CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (if not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b. KIND OF BUSINESS OR INDUSTRY
Salisbury			Deer's Head State Hospital			As Home			
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>	
Maryland			Caroline			Denton		13e. STREET AND NUMBER	
								Rt. #1, Box 219	
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME						
First Middle Last			First Middle Last						
HENRY RAMSEY			ALAMBA E WING						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b. SOCIAL SECURITY NO.			17 INFORMANT Address			
No						GERTRUDE LORD DENTON, MD.			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART I DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Acute pulmonary edema</u>									1 hour
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Arteriosclerotic cardiovascular disease</u>									years
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Multiple cerebral vascular accidents.</u>									
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)									
7-2-1									
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)			21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (A) (this hospital) attended the deceased from <u>7/15</u> , 19 <u>68</u> , to <u>8/18</u> , 19 <u>68</u> , that (X) (we) last saw the deceased alive on <u>8/18</u> , 1968, and that in (our) opinion death occurred on the date and hour and from the causes stated above, (A) (we) (did) (not) view the body after death.									
22b. SIGNATURE						DEGREE ATTENDING PHYS <input type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>		22c. DATE SIGNED	
A. C. Mitchell, M. D.								8/19/68	
22d. PHYSICIAN'S NAME (Type)						22e. ADDRESS			
A. C. Mitchell, M. D.						Deer's Head State Hospital, Salisbury, Md.			
23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)		
Burial			AUG 22, 1968		RED CLAY CREEK		NEWCASTLE, DEL.		
24. FUNERAL DIRECTOR			ADDRESS			25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE	
CHARLES MOORE			DENTON MD.			DATAUG 26 1968		Charles Judge	

88 0881 J/1.4AC

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NRB

VA HOME

ALWADA F MANG

QWASD

HFHkd

NO

GERTRUDE FORD (JENSON, MD)

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
12277 CERTIFICATE OF DEATH											
1 DECEASED-NAME (Type or print)			First Middle Last			2a DATE OF DEATH			2b. HOUR		
Charles			SPARPAGLIONE			August 23 68			12 20 A M		
3 SEX		4. RACE		5. DATE OF BIRTH			6 AGE (In years last birthday)		IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS. HOURS MIN
Male		White		Jan. 13, 1901			67 YRS				
7a BIRTHPLACE (State or foreign country)			7b. CITIZEN OF WHAT COUNTRY?			8 MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH		
New Jersey			USA						Wicomico Md		
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY		
Salisbury-Peninsula			General Hospital			Retired Seaman			Retired		
13a USUAL RESIDENCE (Where deceased lived, admission) STATE			13b COUNTY			13c CITY OR TOWN			13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
Del.			Sussex			Frankford			13e STREET AND NUMBER		
									Clayton Street		
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME								
First Middle Last			First Middle Last								
Miro A. Sparpaglione			Mary T. Sparpaglione								
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)			16b SOCIAL SECURITY NO			17. INFORMANT			Address		
No			180-14-4575			Mrs. Florence Sparpaglione			Frankford		
18 CAUSE OF DEATH (Enter only one cause per line for (a) (b) and (c))											
PART I. DEATH WAS CAUSED BY:											
IMMEDIATE CAUSE (a) <u>Carcinoma</u>											
157.9 DUE TO, OR AS A CONSEQUENCE OF											
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last											
(b) <u>Carcinoma pancreas</u>											
DUE TO, OR AS A CONSEQUENCE OF											
(c)											
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)											
MEDICAL CERTIFICATION											
19a DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a AUTOPSY?			20b IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
8-8-68			Belonging Obstruction			YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21a. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC			21f LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from <u>7/29</u> , 19 <u>68</u> , to <u>8/23</u> , 19 <u>68</u> , that (I) (we) last saw the deceased alive on <u>8/23</u> , 19 <u>68</u> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death											
22b SIGNATURE			22c DATE SIGNED			22d PHYSICIAN'S NAME (Type)			22e ADDRESS		
Richard E. Hupe			8/24/68			DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>					
23a BURIAL CREMATION, REMOVAL (Specify)			23b DATE			23c NAME OF CEMETERY OR CREMATORY			23d LOCATION (City or Town) (County) (State)		
Burial			August 25, 1968			Carey's Cemetery			Frankford Sussex, Del.		
24 FUNERAL DIRECTOR			25a REC'D BY REGISTRAR			25b REGISTRAR'S SIGNATURE					
William G. Nelson			SEP 9 1968			Charles Judge					



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 72 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form-PM3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

## DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

### 12278 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

10288

1 DECEASED NAME (Type or Print)		First Middle Last		2a DATE KNOWN OF DEATH		2b HOUR	
ESCHOL JAMES STEPHENSON				Month Day Year		10:50	
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years last birthday)	IF UNDER 1 YEAR	IF UNDER 24 HRS.	2c DATE PRONOUNCED DEAD	
M	W	MAR. 18 1912	56 YRS	MONTHS DAYS	HOURS MIN	Month 8 Day 10 Year 19	
7a BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH	
BERLIN MD		U.S.A.				Wicomico Md.	
10 CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY	
Salisbury		Peninsula General		OPERATOR		CONSTRUCTION	
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS?	
Md.		Worcester		Berlin		YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME		15. MOTHER'S MAIDEN NAME		13e STREET AND NUMBER			
First Middle Last		First Middle Last		Route 2			
ERNEST STEPHENSON		ROSA WEBB					
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes no, if unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS	
No		218-20-4636		MRS. E.J. STEPHENSON		BERLIN MD	
18 CAUSE OF DEATH (Enter any one cause per line for (a), (b) and (c))							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) Lobar pneumonia							days
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last.							1 month
(b) 2nd & 3rd degree burns of 50% of body surface							
(c) DUE TO, OR AS A CONSEQUENCE OF							
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)							
9153							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY?	
						YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input checked="" type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1. or Part 2, Item 18)			
		11:30 AM 7-8-68		Butane gas tank exploded.			
21d. INJURY OCCURRED WHILE AT WORK <input checked="" type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory, office, building, etc)		21f. LOCATION Street or RFD No		City or Town County State	
		factory development		Ocean Pines, near Berlin, Worcester, MD			
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from. Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>							
ACTUAL SIGNATURE		CHIEF MEDICAL EXAMINER		22b. DATE SIGNED			
Earl L. Royer, M.D.				August 13, 1968			
EXAMINER'S NAME (Type)		ASSISTANT MEDICAL EXAMINER		DEPUTY MEDICAL EXAMINER			
409 Camden Ave., Salisbury, Md				ADDRESS (Street, city, town, or county)			
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town) (County) (State)	
Burial		8/13/68		NEW HOPE		Willards Wicomico	
24. FUNERAL DIRECTOR		25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
Burba Funeral Home, Berlin, Md.		DATE AUG 15 1968		f Charles Judge			





**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form "PM-3" Page 5 may be retained for your files.

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**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**12279 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

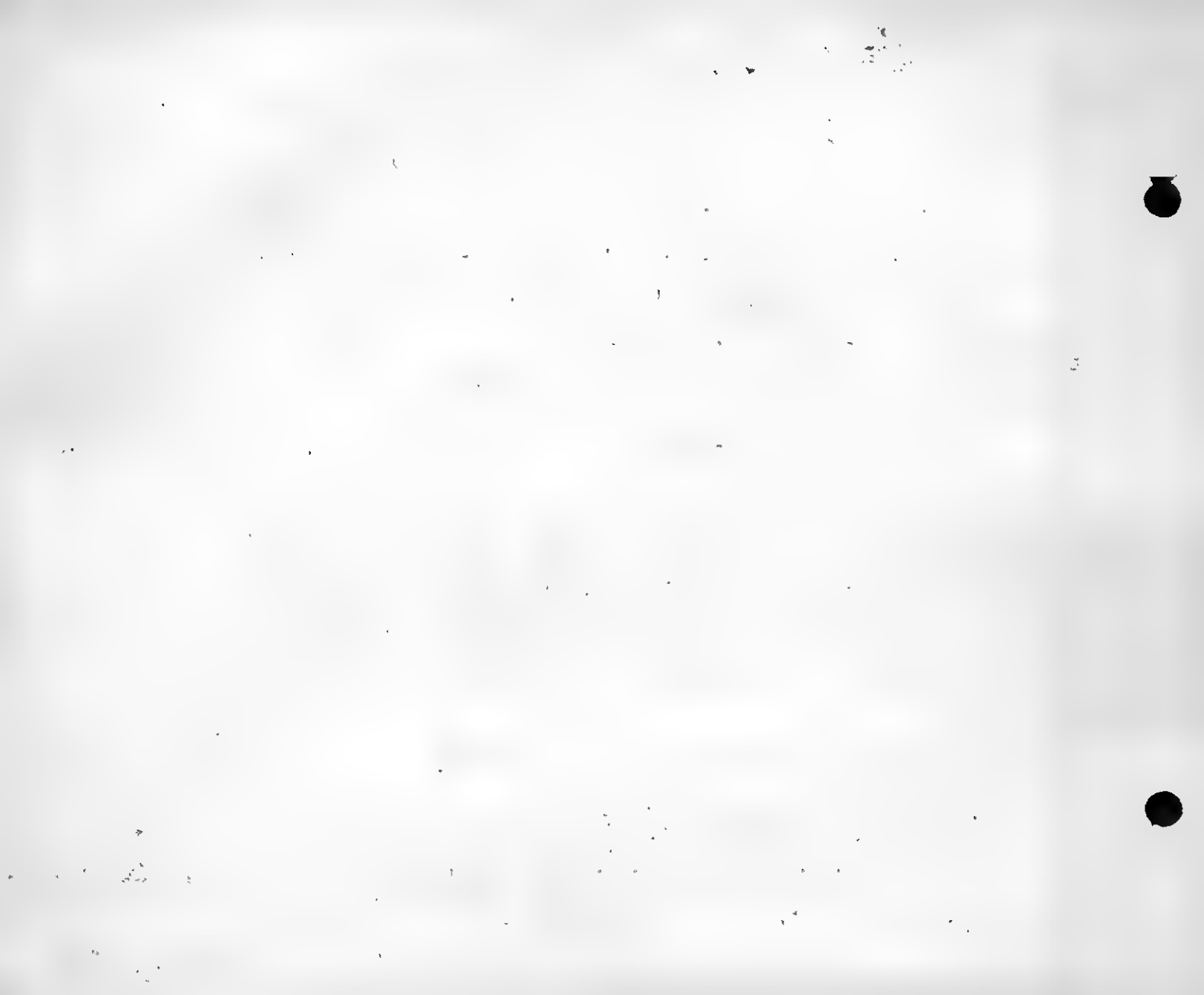
1 DECEASED-NAME (Type or Print)		First	Middle	Last	2a DATE KNOWN OF DEATH MATED	Month	Day	Year	2b HOUR
WILLIAM				STERLING	<input checked="" type="checkbox"/> 8-31-68	19	9	9	30 P M
3 SEX	4 RACE	5 DATE OF BIRTH		6 AGE (in years last birthday)	IF UNDER 1 YEAR MONTHS		IF UNDER 24 HRS HOURS		MIN.
M	AA	DEC. 7, 1904		63 YRS					
7a BIRTHPLACE (State or foreign country)		7b CITIZEN OF WHAT COUNTRY?		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH				
SOMERSET		U.S.			Wicomico Md				
10. CITY OR TOWN OF DEATH		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a USUAL OCCUPATION (Kind of work done during most of working life even if retired)		12b KIND OF BUSINESS OR INDUSTRY			
Salisbury		Peninsula General		LABORER					
13a USUAL RESIDENCE (Where deceased lived, if institution admission) STATE		13b COUNTY		13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER	
Md.		Somerset		Marion				Rural	
14 FATHER'S NAME		First	Middle	Last	15 MOTHER'S MAIDEN NAME		First	Middle	Last
FRIED				STERLING	ALICE HALL				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b SOCIAL SECURITY NO		17 INFORMANT		ADDRESS			
No		215-26-4290		DELSIE SAUNDERS		MARION MD			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Ruptured liver</u> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <u>2 hours</u>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <u>1. 4</u>									
19a DATE OF OPERATION		19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>			
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH		21b TIME OF INJURY Month, Day, Year HOUR <u>7:45 PM</u> <u>8-31</u> <u>19 68</u>		21c HOW INJURY OCCURRED (Enter nature of injury in Part 1, or Part 2, Item 18) <u>Was riding bicycle and was struck from behind by auto</u>					
21d INJURY OCCURRED WHERE <input type="checkbox"/> NOT WHERE <input checked="" type="checkbox"/> AT WORK <input type="checkbox"/> AT WORK <input checked="" type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.) <u>road</u>		21f LOCATION Street or R.F.D. No City or Town County State <u>Route 667, near Marion, Somerset, Md.</u>					
22a I certify that I took charge of the remains described above, held an Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from. Natural causes <input type="checkbox"/> , Accident <input checked="" type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>									
ACTUAL SIGNATURE		Earl L. Royer, M.D.				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		22b. DATE SIGNED	
EXAMINER'S NAME (Type)		409 Camden Ave., Salisbury, Md				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		3ept. 3, 1968	
23a BURIAL, CREMATION, REMOVAL (Specify)		23b DATE		23c NAME OF CEMETERY OR CREMATORY		23d LOCATION (City or Town) (County) (State)			
Burial		9/3/68		Asbury		Crisfield Md.			
24 FUNERAL DIRECTOR		ADDRESS				25a REC'D BY REG STRAR		25b REGISTRAR'S SIGNATURE	
Anthony Ward, Crisfield, Md.						SEP 5 1968		J Charles Judge	



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
12230 CERTIFICATE OF DEATH										
1. DECEASED NAME (Type or print) <b>SADIE</b>			First Middle Last <b>TARR</b>			2a. DATE OF DEATH Month <b>August</b> Day <b>8</b> Year <b>1968</b>		2b. HOUR <b>5:35PM</b>		
3 SEX <b>Female</b>		4 RACE <b>White</b>		5. DATE OF BIRTH <b>August 1, 1884</b>		6 AGE (In years last birthday) <b>84</b> YRS.		IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN.		
7a BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>WICOMICO</b> Md.				
10. CITY OR TOWN OF DEATH <b>Salisbury</b>			11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Deer's Head State Hospital</b>			12a USUAL OCCUPATION (Kind of work done during most of working life even if retired.) <b>Housewife</b>		12b. KIND OF BUSINESS OR INDUSTRY		
13a U.S. RESIDENCE (Where deceased lived admission) STATE <b>Maryland</b>			13b INSTITUTION, Residence before admission) COUNTY <b>Queen Anne's</b>		13c CITY OR TOWN <b>Grasonville</b>		13d INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER <b>xx</b>	
14 FATHER'S NAME First <b>William</b> Middle <b>E.</b> Last <b>Tarr</b>			15. MOTHER'S M.A.DEN NAME First <b>Unknown</b> Middle Last							
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, na, or unknown)			16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Harvey Ruth--Grasonville, Maryland</b> Address					
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Carcinoma of right breast with extensive metastasis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. <b>170X</b> (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____									APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>Years.</b>	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Arteriosclerotic heart disease. Diabetes mellitus.</b>										
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED			20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?		
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 19			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)				
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY) OFFICE BUILDING, ETC.			21f. LOCATION Street or R.F.D. No. City or Town County State				
22a. I certify that <input checked="" type="checkbox"/> (this hospital) attended the deceased from <b>April 1, 1968</b> to <b>August 8, 1968</b> , that <input checked="" type="checkbox"/> (we) last saw the deceased alive on <b>August 8, 1968</b> , and that in <input checked="" type="checkbox"/> (our) opinion death occurred on the date and hour and from the causes stated above, <input checked="" type="checkbox"/> (we) did <input checked="" type="checkbox"/> (did not) view the body after death.										
22b SIGNATURE <b>C. H. Winnacott, M. D.</b> DEGREE ATTENDING PHYS. <input type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input checked="" type="checkbox"/>						22c. DATE SIGNED <b>8/9/68</b>				
22d. PHYSICIAN'S NAME (Type) <b>C. H. Winnacott, M. D.</b>						22e. ADDRESS <b>Deer's Head State Hospital, Salisbury, Md.</b>				
23a BURIAL, CREMATION, or other disposal <b>Interment</b>			23b. DATE <b>Aug. 12</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Chesterfield</b>		23d. LOCATION (City or Town) (County) (State) <b>Centreville Maryland</b>			
24 FUNERAL DIRECTOR <b>Edgar L. Lane</b> ADDRESS <b>Church Hill, Md.</b>						25a. REC'D BY REGISTRAR DATE <b>AUG 13 1968</b>		25b. REGISTRAR'S SIGNATURE <b>Charles Judge</b>		



TO HOSPITAL OR ATTENDING PHYSICIAN: The low requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

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DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12281

CERTIFICATE OF DEATH

1968

1. DECEASED-NAME (Type or print) <i>George M Taylor</i>			2a. DATE OF DEATH Month <i>August</i> Day <i>8</i> Year <i>1968</i>			2b. HOUR <i>1:45</i> P.M.	
3. SEX <i>Male</i>		4. RACE <i>White</i>		5. DATE OF BIRTH <i>Sept. 5, 1908</i>		6. AGE (In years last birthday) <i>59</i> YRS.	
7a. BIRTHPLACE (State or foreign country) <i>Virginia</i>		7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Wicomico</i> Md.	
10. CITY OR TOWN OF DEATH <i>Salisbury-Peninsula</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>General Hospital</i>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) <i>Mechanic</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Auto</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Worcester</i>		13c. CITY OR TOWN <i>Pocomoke</i>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
13e. STREET AND NUMBER <i>R.F.D. 3</i>		14. FATHER'S NAME First <i>Lee</i> Middle <i>--</i> Last <i>Taylor</i>		15. MOTHER'S MAIDEN NAME First <i>Rebecca</i> Middle <i>--</i> Last <i>Tyler</i>			
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, No or unknown <i>NO</i> (If yes give war or dates of service) <i>--</i>		16b. SOCIAL SECURITY NO <i>165-18-6619</i>		17. INFORMANT Address <i>Mrs Eula Taylor, Pocomoke City, Md.</i>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Heart Failure</i> DUE TO, OR AS A CONSEQUENCE OF (b) <i>Cor Pulmonale -</i> DUE TO, OR AS A CONSEQUENCE OF (c) <i>Emphysema &amp; Bronchitis</i>							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>years</i> <i>years</i>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <i>DL</i>							
19a. DATE OF OPERATION <i>8/5/68</i>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED <i>Tracheostomy</i>		20a. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH? <i>Yes</i>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year <i>19</i>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No. City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from <i>8-3-</i> , 19 <i>68</i> , to <i>8-9</i> , 19 <i>68</i> , that (I) (we) lost saw the deceased alive on <i>8-9</i> , 19 <i>68</i> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <i>Joseph C. Fitzgerald</i> M.D. DEGREE				ATTENDING PHYS. <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED <i>8-10-68</i>	
22d. PHYSICIAN'S NAME (Type) <i>Joseph C. Fitzgerald, M.D.</i>				22e. ADDRESS <i>Salisbury, Maryland</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>8-12-1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>First Baptist</i>		23d. LOCATION (City or Town) (County) (State) <i>Pocomoke - Wor. - Md.</i>	
24. FUNERAL DIRECTOR <i>Robert H. Watson</i> ADDRESS <i>Pocomoke City, Md.</i>				25a. REC'D BY REGISTRAR DATE <i>AUG 14 1968</i>		25b. REGISTRAR'S SIGNATURE <i>Charles Judge</i>	



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VR A15 (4)  
30M REV 1-68

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12282

CERTIFICATE OF DEATH

1 DECEASED NAME (Type or print) First Middle Last LULA EXMA THOMPSON			2a. DATE OF DEATH Month Day Year August 13 1968			2b. HOUR 9:30 M	
3 SEX FEMALE		4 RACE White		5 DATE OF BIRTH August 11, 1895		6 AGE (In years last birthday) 73 YRS.	
7a. BIRTHPLACE (State or foreign country) BETHUN MD		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico Md.	
10. CITY OR TOWN OF DEATH Salisbury-Peninsula		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) General Hospital		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired) HOUSEWIFE		12b. KIND OF BUSINESS OR INDUSTRY OWN HOME	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE MARYLAND		13b. COUNTY BEGUN		13c. CITY OR TOWN BEGUN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
14. FATHER'S NAME First Middle Last JAMES BRADFORD		15. MOTHER'S MAIDEN NAME First Middle Last MAGGIE WILLIAMS		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (If in, give war or dates of service) No		16b. SOCIAL SECURITY NO 820-00-0375	
16c. INFORMANT Mr. W.M. K. THOMPSON		16d. ADDRESS RD 2 BERLIN MD		18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) _____ DUE TO, OR AS A CONSEQUENCE OF (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ 2509 Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost Asc v P. Diabetes		APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH years years	
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART I (a)							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or RFD No City or Town County State			
22a. I certify that (I) (this hospital) attended the deceased from 8-7, 1968, to 8-13, 1968, that (I) (we) last saw the deceased alive on 8-13, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death							
22b. SIGNATURE James C. Fitzgerald, M.D.				22c. DATE SIGNED 8-13-68		22d. PHYSICIAN'S NAME (Type) A. Burbage	
23a. BURIAL, CREMATION, REMOVAL (Specify) BURIAL		23b. DATE 8/17/68		23c. NAME OF CEMETERY OR CREMATORY EVERGREEN		23d. LOCATION (City or Town) (County) (State) Berlin Wic. Md.	
24. FUNERAL DIRECTOR A. Burbage				25a. REC'D BY REG. STRAR DATE AUG 16 1968		25b. REG. STRAR'S SIGNATURE Charles Judge	





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MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201 12283 CERTIFICATE OF DEATH													
1 DECEASED NAME (Type or print)			First		Middle		Last		2a. DATE OF DEATH Month Day Year		2b. HOUR		
HOWARD OSCAR							TIMMONS		August 28 1968		1:05 PM		
3 SEX		4 RACE		5. DATE OF BIRTH				6 AGE (In years last birthday)		7 IF UNDER 1 YEAR		8 IF UNDER 24 HRS	
male		White		January 5, 1922				46 YRS		MONTHS		DAYS	
7a BIRTHPLACE (State or foreign country)			7b. CIT. ZEN OF WHAT COUNTRY?			B. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>			9. COUNTY OF DEATH				
Maryland			USA						Wicomico Md.				
10. CITY OR TOWN OF DEATH			11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)						12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b KIND OF BUSINESS OR INDUSTRY		
Salisbury			Peninsula General Hospital						Truck Driver				
13a USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c CITY OR TOWN		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER			
Maryland			Wicomico			Pittsville		YES <input type="checkbox"/> NO <input type="checkbox"/>		R.D. 1			
14 FATHER'S NAME			15 MOTHER'S MAIDEN NAME										
Oscar Marion			Timmons			Maggie			Davis				
16a WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown			16b SOCIAL SECURITY NO			17. INFORMANT (Wife)			Address R.D. 1				
No			214-28-2964			Mrs. Helen J. Timmons, Pittsville, Maryland							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY. IMMEDIATE CAUSE (a) <u>subdural hemorrhage</u> DUE TO, OR AS A CONSEQUENCE OF <u>hypertension uncontrolled</u> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <u>hypertension uncontrolled</u> DUE TO, OR AS A CONSEQUENCE OF (c)												APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH	
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)													
19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work			21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)				21f. LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from 8/27, 19, to 8/28, 19, that (I) (we) lost saw the deceased alive on 8/27/68, 19, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (d d not) view the body after death													
22b. SIGNATURE <u>Carrie Hearn</u>								22c. DATE SIGNED		August 28, 1968			
22d. PHYSICIAN'S NAME (Type) Dr. Carrie Hearn								22e. ADDRESS		226 N. Division St., Salisbury, Maryland			
23a. B. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE		23c. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town) (County) (State)				
Burial			August 30, 1968		Jones Family Cemetery				Wicomico, Maryland				
24. FUNERAL DIRECTOR								25a. REC'D BY REGISTRAR		25b. REGISTRAR'S SIGNATURE			
HOLLOWAY & COMPANY, SALISBURY, MARYLAND								DATE AUG 30 1968		<u>[Signature]</u>			



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VR A15  
30M REV

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12284

CERTIFICATE OF DEATH

12294

1. DECEASED NAME (Type or print) <b>Joseph Vincent Towers</b>			2a. DATE OF DEATH Month <b>August</b> Day <b>16</b> Year <b>1968</b>			2b. HOUR a.m. or p.m. <b>8:26 a.m.</b>	
3. SEX <b>male</b>		4. RACE <b>white</b>		5. DATE OF BIRTH <b>June 23, 1896</b>		6. AGE (In years lost birthday) <b>72</b> YRS	
7a. BIRTHPLACE (State or foreign country) <b>Maryland</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b> Md.	
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Pine Bluff State Hosp.</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.) <b>Laborer</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>-</b>	
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE <b>Maryland</b>		13b. COUNTY <b>Caroline</b>		13c. CITY OR TOWN <b>Federalsburg</b>		13d. INSIDE CITY LIMITS? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO	
14. FATHER'S NAME First <b>John</b> Middle <b>R.</b> Last <b>Towers</b>		15. MOTHER'S MAIDEN NAME First <b>Anna</b> Middle <b>-</b> Last <b>Slacum</b>					
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) <input checked="" type="checkbox"/> No		16b. SOCIAL SECURITY NO. <b>216-03-7326</b>		17. INFORMANT <b>records of</b> Address <b>Pine Bluff State Hospital</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Cor Pulmonale</b> <b>0119</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____							APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>Pulmonary Tuberculosis</b>							
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? <input type="checkbox"/> YES <input checked="" type="checkbox"/> NO		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part I or Part 2, Item 18)			
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State			
22a. I certify that (X) (this hospital) attended the deceased from <b>Mar. 19, 1962</b> , to <b>Aug. 16, 1968</b> , that (X) (we) last saw the deceased alive on <b>Aug. 16, 1968</b> and that in (our) (our) opinion death occurred on the date and hour and from the causes stated above, (X) (we) (did) (did not) view the body after death.							
22b. SIGNATURE <b>E. P. Ritchings</b>		DEGREE <b>M.D.</b>		ATTENDING PHYSICIAN <input type="checkbox"/> MED. DIRECTOR <input checked="" type="checkbox"/> STAFF PHYSICIAN <input type="checkbox"/>		22c. DATE SIGNED <b>Aug. 16, 1968</b>	
22d. PHYSICIAN'S NAME (Type) <b>E. P. Ritchings, M.D.</b>		22e. ADDRESS <b>Pine Bluff State Hospital</b>					
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>Burial</b>		23b. DATE <b>Aug 20, 1968</b>		23c. NAME OF CEMETERY OR CREMATORY <b>Still Crest Cemetery</b>		23d. LOCATION (City or Town) (County) (State)	
24. FUNERAL DIRECTOR <b>Harvey Williams - Federalsburg, Md.</b>		ADDRESS		25a. REC'D BY REGISTRAR DATE <b>AUG 26 1968</b>		25b. REGISTRAR'S SIGNATURE <b>James J. Judge</b>	



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VR A15  
30M REV

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

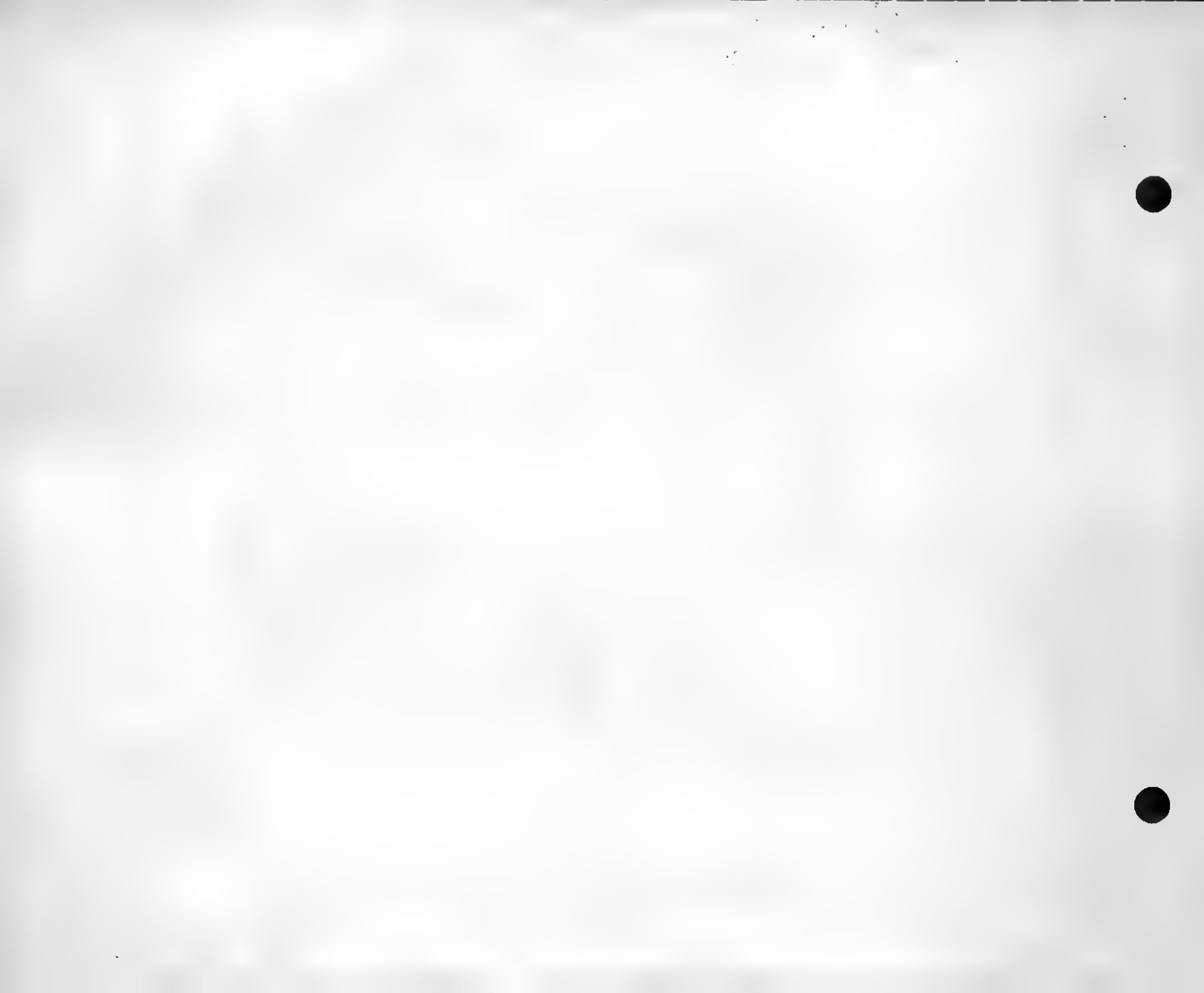
12283

CERTIFICATE OF DEATH

1 DECEASED-NAME (Type or print) <b>JADIE MAE WALKER</b>			2a DATE OF DEATH Month <b>August</b> Day <b>26</b> Year <b>1968</b>			2b HOUR <b>1:14</b> M							
3 SEX <b>FEMALE</b>		4 RACE <b>Negro</b>		5. DATE OF BIRTH <b>10-28-29</b>		6. AGE (In years lost birthday) <b>38</b> YRS		IF UNDER 1 YEAR MONTHS DAYS		IF UNDER 24 HRS. HOURS MIN.			
7a. BIRTHPLACE (State or foreign country) <b>Salisbury</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A</b>		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b> Md							
10 CITY OR TOWN OF DEATH <b>Salisbury</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Peninsula General Hospital</b>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)			12b KIND OF BUSINESS OR INDUSTRY				
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>MARYLAND</b>				13b COUNTY <b>Wicomico</b>		13c CITY OR TOWN <b>Salisbury</b>		13d INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e STREET AND NUMBER <b>3 WADEN AVE</b>			
14. FATHER'S NAME First Middle Last <b>L Ernest Newkirk</b>				15 MOTHER'S MAIDEN NAME First Middle Last <b>Sadie Barkley</b>									
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown) (If yes give war or dates of service)				16b SOCIAL SECURITY NO <b>218-24-5188</b>		17 INFORMANT <b>Dorothy Kellan</b> Address <b>328 Belvedere Ave Baltimore, Md</b>							
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <b>Gangrene</b> <b>135 X</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____ APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>unknown</b>													
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <b>138</b>													
19a DATE OF OPERATION			19b CONDITION FOR WHICH OPERATION WAS PERFORMED				20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?				
21a ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)			21b TIME OF INJURY HOUR A.M. Month Day Year P.M. 19				21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> or work at work			21e PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE, BUILDING, ETC)				21f LOCATION Street or R.F.D. No City or Town County State						
22a. I certify that (I) (this hospital) attended the deceased from <b>8-25-68</b> , to <b>8-26-68</b> , that (I) (we) last saw the deceased alive on <b>8-26-68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.													
22b SIGNATURE <b>William R. Elder</b>						DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c DATE SIGNED <b>8-26-68</b>					
22d PHYSICIAN'S NAME (Type)						22e ADDRESS							
23a BURIAL, CREMATION, REMOVAL (Specify)			23b DATE <b>8-31-68</b>		23c NAME OF CEMETERY OR CREMATORY <b>GREEN ACRES</b>			23d LOCATION (City or Town) (County) (State) <b>Salisbury Wico Md.</b>					
24. FUNERAL DIRECTOR <b>L. Jolley</b>						ADDRESS <b>Jersey Rd. Rt. #2 Salisbury, Md.</b>		25a. REC'D BY REGISTRAR DATE <b>SEP 5 1968</b>		25b REGISTRAR'S SIGNATURE <b>Charles Judge</b>			

MEDICAL CERTIFICATION

X



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please return the carbon papers. Page 4 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

VR A15  
304 REV

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
12286  
CERTIFICATE OF DEATH

12286

1. DECEASED NAME (Type or print) First Middle Last <i>Austin Edward WARREN</i>			2a. DATE OF DEATH Month Day Year <i>AUGUST 1 1968</i>		2b. HOUR <i>2.00am</i>
3. SEX <i>Male</i>	4. RACE <i>White</i>	5. DATE OF BIRTH <i>Feb. 18 1879</i>		6. AGE (In years last birthday) <i>89</i> YRS.	IF UNDER 1 YEAR MONTHS DAYS IF UNDER 24 HRS. HOURS MIN
7a. BIRTHPLACE (State or foreign country) <i>Maryland</i>	7b. CITIZEN OF WHAT COUNTRY? <i>U.S.A.</i>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <i>Wicomico</i> Md.	
10. CITY OR TOWN OF DEATH <i>Salisbury - Peninsula General Hospital</i>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <i>Bellevue M.H. Hospital</i>		12b. KIND OF BUSINESS OR INDUSTRY <i>Lumber</i>	
13a. USUAL RESIDENCE (Where deceased lived, if institution Residence before admission) STATE <i>Maryland</i>		13b. COUNTY <i>Worcester</i>	13c. CITY OR TOWN <i>Snow Hill</i>	13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/> 13e. STREET AND NUMBER <i>Bay Street</i>	
14. FATHER'S NAME First Middle Last <i>Gaylord L. Warren</i>			15. MOTHER'S MAIDEN NAME First Middle Last <i>Ellen B. Cropper</i>		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown (If yes give year or dates of service) <i>No</i>		16b. SOCIAL SECURITY NO <i>221 09 1217</i>	17. INFORMANT Address <i>Mrs. Mary B. Warren Snow Hill Md</i>		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a): <i>Cerebral Thrombosis (x2)</i> Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last: <i>Cerebral Arteriosclerosis</i> (b) <i>Cerebral Arteriosclerosis</i> (c) <i>Not Known</i>					APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <i>3 days</i>
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)					
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>	
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY Hour A.M. Month Day Year P.M. 1968		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 1B)	
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> of work <input type="checkbox"/>		21e. PLACE OF INJURY (At home farm street factory, office building, etc.)		21f. LOCATION Street or R.F.D. No City or Town County State	
22a. I certify that (I) (this hospital) attended the deceased from <i>7/28/68</i> to <i>8/1/68</i> , that (I) <del>(we)</del> last saw the deceased alive on <i>7/31/68</i> , and that in (my) <del>(our)</del> opinion death occurred on the date and hour and from the causes stated above, (I) <del>(we)</del> (did) <del>(did not)</del> view the body after death.					
22b. SIGNATURE <i>[Signature]</i>			22c. DATE SIGNED		22d. PHYSICIAN'S NAME (Type) <i>[Signature]</i>
22e. DEGREE ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22f. ADDRESS <i>[Signature]</i>			
23a. BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>		23b. DATE <i>Aug. 3 1968</i>		23c. NAME OF CEMETERY OR CREMATORY <i>Bates Methodist</i>	
23d. LOCATION (City or Town) (County) (State) <i>Snow Hill Md</i>		25a. REC'D BY REGISTRAR <i>[Signature]</i>		25b. REGISTRAR'S SIGNATURE <i>[Signature]</i>	
24. FUNERAL DIRECTOR <i>[Signature]</i>		25c. ADDRESS <i>Snow Hill Md</i>			





FOR STATE  
HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PMS-Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201													
Item # 1, Film 3475 1. MEDICAL EXAMINER'S CERTIFICATE OF DEATH 12287													
1 DECEASED-NAME (Type or Print) <i>Clarenda Handy Washington</i>						2a DATE KNOWN OF DEATH Month <input checked="" type="checkbox"/> 8 Day 24 Year 1968		2b HOUR 5:30 PM					
3 SEX <i>F</i>		4 RACE <i>AA</i>		5 DATE OF BIRTH <i>NOV. 21-99</i>		6 AGE (In years last birthday) <i>68</i> YRS		7 IF UNDER 1 YEAR MONTHS _____ DAYS _____		8 IF UNDER 24 HRS HOURS _____ MIN. _____			
7a BIRTHPLACE (State or foreign country) <i>Baltimore</i>			7b CITIZEN OF WHAT COUNTRY? <i>U.S.A</i>			8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			9 COUNTY OF DEATH <i>Wicomico</i>				
10 CITY OR TOWN OF DEATH <i>Salisbury</i>				11 NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address) <i>Peninsula Gen. Hosp. DCA</i>				12a USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b KIND OF BUSINESS OR INDUSTRY <i>W Elder</i>		
13a USUAL RESIDENCE (Where deceased lived, admission) STATE <i>Maryland</i> COUNTY <i>Worcester</i>						13c CITY OR TOWN <i>Berlin</i>		13d INSIDE CITY, M-157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e STREET AND NUMBER <i>P.O. Box 345, Berlin, Md.</i>			
14 FATHER'S NAME First Middle Last <i>John Wesley WARD</i>						15 MOTHER'S MAIDEN NAME First Middle Last <i>Ella Levi</i>							
16a WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)				16b SOCIAL SECURITY NO <i>214-32-2680</i>		17 INFORMANT <i>John N. Washington</i>				ADDRESS <i>P.O. Box 345 Berlin, Md.</i>			
18 CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).) PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <i>Carcinoma of Pancreas</i> <i>157.9</i> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) _____ DUE TO, OR AS A CONSEQUENCE OF (c) _____										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH			
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a) <i>157.9</i>													
19a DATE OF OPERATION				19b CONDITION FOR WHICH OPERATION WAS PERFORMED?				20 AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>					
21a EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING CAUSE OF DEATH <input type="checkbox"/>			21b TIME OF INJURY Month, Day, Year HOUR A.M. _____ P.M. <i>19</i>			21c HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, item 18.)							
21d INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f LOCATION Street or R.F.D. No		City or Town		County		State		
22a I certify that I took charge of the remains described above, held on death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE <i>Charles Judge</i>				EXAMINER'S NAME (Type) <i>M.D.</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>	
								ADDRESS (Street, city, town, or county)		22b DATE SIGNED <i>8-26-68</i>			
23a BURIAL, CREMATION, REMOVAL (Specify) <i>Burial</i>			23b DATE <i>8-28-68</i>		23c NAME OF CEMETERY OR CREMATORY <i>St. James</i>			23d LOCATION (City or Town) <i>Snow Hill Wore. Md.</i>		(County)		(State)	
24 FUNERAL DIRECTOR <i>Loretta B. Jolley Jersey Rd. Salisbury</i>				ADDRESS				25a RECD BY REGISTRAR <i>SEP 5 1968</i>		25b REGISTRAR'S SIGNATURE <i>Charles Judge</i>			



# FOR STATE HEALTH DEPT.

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with Form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 1 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201										
12280 MEDICAL EXAMINER'S CERTIFICATE OF DEATH										
1. DECEASED-NAME (Type or Print)		First JAKE		Middle		Last WATSON		2a. DATE KNOWN OF DEATH Month Day Year 8-14-68 19		2b. HOUR 4:20 AM
3. SEX Male	4. RACE AA	5. DATE OF BIRTH Mar. 10, 1924		6. AGE (in years last birthday) 44 YRS		IF UNDER 1 YEAR MONTHS DAYS HOURS MIN		2c. DATE PRONOUNCED DEAD Month Day Year 8 14 19		2d. HOUR 4:20 AM
7a. BIRTHPLACE (State or foreign country) Tabor, N.C.		7b. CITIZEN OF WHAT COUNTRY? U.S.A.		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH Wicomico		Md.		
10. CITY OR TOWN OF DEATH Salisbury		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) Peninsula General				12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY		
13a. USUAL RESIDENCE (Where deceased lived, if institution admission) STATE Md.		13b. COUNTY Worcester		13c. CITY OR TOWN Berlin		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER B.F.L. #3		
14. FATHER'S NAME First Middle Last Joseph Watson		15. MOTHER'S MAIDEN NAME First Middle Last Nancy Savage		16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO. 220-12-0024		17. INFORMANT Willie Watson		ADDRESS 110 Cherry Ave Mt. Vernon, N.Y.
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1 DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) 492X Acute tracheobronchitis DUE TO, OR AS A CONSEQUENCE OF (b) Cor Pulmonale DUE TO, OR AS A CONSEQUENCE OF (c) Emphysema Conditions, if any, which gave rise to immediate cause (a) stating the underlying cause lost: 5										APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH days year year
PART 2 OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) Arteriosclerotic cardio-vascular disease.										
19a. DATE OF OPERATION				19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		
21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year HOUR A.M. P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)						
21d. INJURY OCCURRED WHILE <input type="checkbox"/> NOT WHILE <input type="checkbox"/> AT WORK AT WORK		21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)		21f. LOCATION Street or R.F.D. No		City or Town		County		State
22a. I certify that I took charge of the remains described above, held on Autopsy <input checked="" type="checkbox"/> , Inspection <input checked="" type="checkbox"/> , Inquiry <input checked="" type="checkbox"/> , and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> , Accident <input type="checkbox"/> , Suicide <input type="checkbox"/> , Homicide <input type="checkbox"/> , Undetermined manner <input type="checkbox"/>										
ACTUAL SIGNATURE EXAMINER'S NAME (Type)		Earl L. Royer, M.D. 409 Camden Ave., Salisbury, Md.				CHIEF MEDICAL EXAMINER <input type="checkbox"/> ASSISTANT MEDICAL EXAMINER <input type="checkbox"/> DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED August 16, 1968		
23a. BURIAL CREMATION, REMOVAL (Specify)		23b. DATE 8-19-68		23c. NAME OF CEMETERY OR CREMATORY New Bethel		23d. LOCATION (City or Town) (County) (State) Berlin Wore. Md.				
24. FUNERAL DIRECTOR Jolley Funeral Home, Salisbury, Md.				25a. REC'D BY REGISTRAR DATE AUG 22 1968		25b. REGISTRAR'S SIGNATURE Charles Judge				



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. (If possible, remove carbon papers, pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and if any event, within 72 hours after death.)

VR A15 (4)  
30M REV. 12-67

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201  
122889  
122899  
CERTIFICATE OF DEATH

1. DECEASED NAME (Type or print) <b>LLOYD THOMAS WATSON</b>		2a. DATE OF DEATH Month <b>AUGUST</b> Day <b>6</b> Year <b>1968</b>		2b. HOUR <b>4:15</b> M
3. SEX <b>MALE</b>	4. RACE <b>WHITE</b>	5. DATE OF BIRTH <b>3-27-82</b>	6. AGE (In years last birthday) <b>86</b> YRS	
7a. BIRTHPLACE (State or foreign country) <b>MARYLAND</b>	7b. CITIZEN OF WHAT COUNTRY? <b>USA</b>	8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	9. COUNTY OF DEATH <b>Wicomico</b> Md.	
10. CITY OR TOWN OF DEATH <b>Salisbury - Peninsula General Hospital</b>		11. NAME OF HOSPITAL OR INSTITUTION (If not in hosp to give street address) <b>CARPENTER</b>		12b. KIND OF BUSINESS OR INDUSTRY <b>CARPENTER</b>
13a. USUA. RESIDENCE (Where deceased lived, if institut on. Residence before admission) STATE <b>MARYLAND</b>	13b. COUNTY <b>Wicomico</b>	13c. CITY OR TOWN <b>Hebron</b>	13d. INSIDE CITY LIM 157 YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>	13e. STREET AND NUMBER <b>413 WALNUT STREET</b>
14. FATHER'S NAME First <b>MINUS</b> Middle <b>B.</b> Last <b>WATSON</b>		15. MOTHER'S MAIDEN NAME First <b>ELIZABETH</b> Middle <b>BETTS</b> Last		
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>no</b> (If yes give war or dates of service)		16b. SOCIAL SECURITY NO.		17. INFORMANT <b>Mrs. MARY W. WATSON</b> Address <b>SAME AS 13</b>
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c). PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>Cerebral Thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF (b) <b>Atherosclerotic Cerebrovascular Disease</b> DUE TO, OR AS A CONSEQUENCE OF (c) <b>Concussion of Left Ear</b> Condit ans, if any, which gave rise to immed ate cause (a), stating the underlying cause lost.				
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1 (a)				
19a. DATE OF OPERATION <b>7-26-68</b>		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. <b>19</b>		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC.)		21f. LOCATION Street or R.F.D. No City or Town County State
22a. I certify that (I) (this hospital) attended the deceased from <b>July 26, 1968</b> , to <b>Aug 6, 1968</b> , that (I) (we) last saw the deceased alive on <b>Aug 6, 1968</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.				
22b. SIGNATURE <b>Thomas C. Hill Jr. MD</b>		22c. DATE SIGNED <b>Aug 6, 1968</b>		22d. PHYSICIAN'S NAME (Type) <b>THOMAS C. Hill, Jr. MD</b>
22e. ADDRESS <b>Pine Bluff Rd., Salisbury, Md.</b>		22f. REGISTRAR'S SIGNATURE <b>Charles J. Jones</b>		
23a. BURIAL, CREMATION, REMOVAL (Specify) <b>BURIAL</b>	23b. DATE <b>8-8-68</b>	23c. NAME OF CEMETERY OR CREMATORY <b>MARDELA Cem.</b>	23d. LOCATION (City or Town) (County) (State) <b>MARDELA Md.</b>	23e. REC'D BY REGISTRAR <b>THOMAS T. WALLACE</b>
24. FUNERAL DIRECTOR <b>THOMAS T. WALLACE</b>				



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

**DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201**  
**12290 MEDICAL EXAMINER'S CERTIFICATE OF DEATH**

1 DECEASED-NAME (Type or Print)		First	Middle	Lost	2a. DATE KNOWN OF DEATH		<input checked="" type="checkbox"/> ESTI <input type="checkbox"/> MATED	Month	Day	Year	2b. HOUR		
BONNIE		LOUISE	WEBSTER		8			24	19	68	5:25		
3 SEX	4 RACE	5 DATE OF BIRTH	6 AGE (In years lost birthday)	IF UNDER 1 YEAR MONTHS	DAYS	IF UNDER 24 HRS HOURS	MIN	2c. DATE PRONOUNCED DEAD		Month	Day	Year	2d. HOUR
Female	White	May 12, 1949	19 YRS					8		24	1968	5:25	
7a. BIRTHPLACE (State or foreign country)		7b. CIT. ZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH							
Maryland		U.S.A.				Wicomico							
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USJA. OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY							
Salisbury		Peninsula General Hospital		Never Work Student		None							
13a. USUAL RESIDENCE (Where deceased lived if institution residence before admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		13e. STREET AND NUMBER					
Maryland		Wicomico		Salisbury				305 S. Haven Ave.,					
14. FATHER'S NAME		First	Middle	Lost	15. MOTHER'S MAIDEN NAME		First	Middle	Lost				
Frank		B.	Webster		Louise		Cantwell						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? (Yes, no, or unknown)		16b. SOCIAL SECURITY NO		17. INFORMANT		ADDRESS							
No		None		Mrs. Lula C. Bell, Rumbley, Md.									
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))											APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH		
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Fractured skull</u>													
8147 DUE TO, OR AS A CONSEQUENCE OF													
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost													
(b) DUE TO, OR AS A CONSEQUENCE OF													
(c)													
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)													
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?				20. AUTOPSY?				YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
21a. EXTERNAL CAUSE WAS PRIMARY <input checked="" type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH		21b. TIME OF INJURY Month, Day, Year		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)									
		9:25 P.M. 8-23-68		Pedestrian Struck by CAR									
21d. INJURY OCCURRED WHILE AT WORK <input type="checkbox"/> NOT WHILE AT WORK <input type="checkbox"/>		21e. PLACE OF INJURY (At home, farm, street, factory office building, etc)		21f. LOCATION Street or R.F.D. No		City or Town		County		State			
		Rt. 13 South of Salisbury Wic. Md.											
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input type="checkbox"/> Accident <input checked="" type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>													
ACTUAL SIGNATURE		EXAMINER'S NAME (Type)				CHIEF MEDICAL EXAMINER <input type="checkbox"/>		ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>		DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>		22b. DATE SIGNED	
<u>Philip A. Insley</u>		Philip A. Insley										8-26-68	
ADDRESS		23a. NAME OF CEMETERY OR CREMATORY				23d. LOCATION (City or Town)		(County)		(State)			
Hill Funeral Home Salisbury, Maryland		Siloam Cemetery				Siloam, Wicomico, Maryland							
24. FUNERAL DIRECTOR		23b. DATE		23c. NAME OF CEMETERY OR CREMATORY		23d. LOCATION (City or Town)		(County)		(State)			
		8-27-1968		Siloam Cemetery		Siloam, Wicomico, Maryland							
25a. REC'D BY REG. STRAR		25b. REGISTRAR'S SIGNATURE											
DATE AUG 27 1968		<u>Charles Judge</u>											





TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH  
DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201

12291

CERTIFICATE OF DEATH

1. DECEASED-NAME (Type or print) <b>ARTHUR THOMAS WILLIAMS</b>			2a. DATE OF DEATH Month <b>AUGUST</b> Day <b>28</b> Year <b>1968</b>			2b. HOUR <b>8:55</b> M			
3 SEX <b>MALE</b>		4 RACE <b>W</b>		5. DATE OF BIRTH <b>JAN. 31, 1898</b>		6 AGE (In years last birthday) <b>70</b> YRS		IF UNDER 1 YEAR MONTHS IF UNDER 24 HRS. HOURS MIN.	
7a. BIRTHPLACE (State or foreign country) <b>Berlin Md</b>		7b. CITIZEN OF WHAT COUNTRY? <b>U.S.A.</b>		8 MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH <b>Wicomico</b> Md.			
10. CITY OR TOWN OF DEATH <b>Salisbury</b>		11 NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address) <b>Peninsula General Hospital</b>		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)		12b. KIND OF BUSINESS OR INDUSTRY			
13a. USUAL RESIDENCE (Where deceased lived, if institution. Residence before admission) STATE <b>DELAWARE</b>		13b. COUNTY <b>SUSSEX</b>		13c. CITY OR TOWN <b>BOXPART</b>		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER <b>RFD</b>	
14 FATHER'S NAME First Middle Last <b>HIRAM WILLIAMS</b>			15. MOTHER'S MAIDEN NAME First Middle Last <b>ANNA BEUG ELLIS</b>						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or unknown <b>No</b>		16b. SOCIAL SECURITY NO <b>218-20-6157</b>		17 INFORMANT <b>MRS. BETTY JOHNSON</b>		Address <b>JOHNSONS CORNER DEL.</b>			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c)) PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <b>congenital thrombosis</b> DUE TO, OR AS A CONSEQUENCE OF Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last (b) <b>generalized arteriosclerosis</b> DUE TO, OR AS A CONSEQUENCE OF (c) APPROXIMATE INTERVAL BETWEEN ONSET AND DEATH <b>10</b> years									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a) <b>332X Diabetes mellitus</b>									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19 68		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work at work		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No.		City or Town		County State	
22a. I certify that (I) (this hospital) attended the deceased from <b>8-28</b> , 19 <b>68</b> , to <b>8-28</b> , 19 <b>68</b> , that (I) (we) last saw the deceased alive on <b>8-28</b> , 19 <b>68</b> , and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above (I) (we) (did) (did not) view the body after death									
22b. SIGNATURE <b>John G. Burkley, MD</b>				DEGREE <b>MD</b>		ATTENDING PHYS <input checked="" type="checkbox"/> MED DIRECTOR <input type="checkbox"/> STAFF PHYS <input type="checkbox"/>		22c. DATE SIGNED <b>8/28/68</b>	
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE <b>8/31/68</b>		23c. NAME OF CEMETERY OR CREMATORY <b>EVERGREEN</b>		23d. LOCATION (City or Town) (County) (State) <b>Berlin Wicomico Md</b>			
24. FUNERAL DIRECTOR <b>Anna A. Burbage</b>		ADDRESS <b>Berlin Md</b>		25a. REC'D BY REG STRAR <b>DATE AUG 30 1968</b>		25b. REGISTRAR'S SIGNATURE <b>John A. Jones</b>			



TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the State Dept. of Health prior to burial, cremation, or removal, and in any event, within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201									
12292 <b>CERTIFICATE OF DEATH</b>									
1. DECEASED-NAME (Type or print)			2a. DATE OF DEATH			2b. HDUR			
First Middle Last Rachel R. Willing			Month 5 Day 1968			8:05 A M			
3 SEX		4 RACE		5. DATE OF BIRTH		6 AGE (in years last birthday)		7. UNDER 1 YEAR	
Female		white		April 30, 1893		76 YRS		MONTHS DAYS HOURS MIN	
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>		9. COUNTY OF DEATH			
Maryland		U.S.A.				Wicomico County Md			
10. CITY OR TOWN OF DEATH		11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)		12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired.)		12b. KIND OF BUSINESS OR INDUSTRY			
Salisbury, Mo.		Beth St., Salisbury, Md.		None		None			
13a. USUAL RESIDENCE (Where deceased lived, if not last on admission) STATE		13b. COUNTY		13c. CITY OR TOWN		13d. INSIDE CITY LIMITS? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		13e. STREET AND NUMBER	
Md		Wicomico		Salisbury				Quantico Road	
14. FATHER'S NAME First Middle Last			15. MOTHER'S MAIDEN NAME First Middle Last						
James W. T. Robertson			Mary Robertson						
16a. WAS DECEASED EVER IN U.S. ARMED FORCES? Yes, no, or (unknown)			16b. SOCIAL SECURITY NO.			17. INFORMANT Address			
						Mrs Charles Lawrence Tangewood Rd. Baltimore, Md. 21204			
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c))									
PART 1. DEATH WAS CAUSED BY IMMEDIATE CAUSE (a) <u>Cardiac Arrest</u>									
DUE TO, OR AS A CONSEQUENCE OF (b) <u>Hypertensive C.V. Disease</u>									
DUE TO, OR AS A CONSEQUENCE OF (c) <u>Stroke</u>									
PART 2. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE OR CONDITION GIVEN IN PART 1(a)									
41. X									
19a. DATE OF OPERATION		19b. CONDITION FOR WHICH OPERATION WAS PERFORMED		20a. AUTOPSY? YES <input type="checkbox"/> NO <input type="checkbox"/>		20b. IF YES, WERE FINDINGS CONSIDERED IN CERTIFYING CAUSES OF DEATH?			
21a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (If either, notify medical examiner)		21b. TIME OF INJURY HOUR A.M. Month Day Year P.M. 19		21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18)					
21d. INJURY OCCURRED While <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>		21e. PLACE OF INJURY (AT HOME, FARM, STREET, FACTORY, OFFICE BUILDING, ETC)		21f. LOCATION Street or R.F.D. No City or Town County State					
22a. I certify that (I) (this hospital) attended the deceased from 8-24, 1955 to 8-5, 1968, that (I) (we) last saw the deceased alive on 8-6, 1968, and that in (my) (our) opinion death occurred on the date and hour and from the causes stated above, (I) (we) (did) (did not) view the body after death.									
22b. SIGNATURE <u>W. G. B. Smith</u> DEGREE				ATTENDING PHYS <input checked="" type="checkbox"/> MED. DIRECTOR <input type="checkbox"/> STAFF PHYS. <input type="checkbox"/>		22c. DATE SIGNED 8-6-68			
22d. PHYSICIAN'S NAME (Type)				22e. ADDRESS					
23a. BURIAL, CREMATION, REMOVAL (Specify)		23b. DATE 8/7/68		23c. NAME OF CEMETERY OR CREMATORY Bivalve Cem.		23d. LOCATION (City or Town) (County) (State) Bivalve Md			
24. FUNERAL DIRECTOR <u>Levin R. Wilson</u>				ADDRESS <u>Princess Anne, Md.</u>		25a. REC'D BY REGISTRAR DATE AUG 12 1968		25b. REGISTRAR'S SIGNATURE <u>Charles Judge</u>	



**FOR STATE  
HEALTH DEPT.**

TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. Any delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your files.

TO FUNERAL DIRECTOR: Page 3 should be used as a burial-transit permit. File pages 1 and 2 with the State Department of Health prior to burial, cremation, or removal, and in any event within 72 hours after death.

DIVISION OF VITAL RECORDS, 301 W. PRESTON STREET, BALTIMORE, MARYLAND 21201											
MEDICAL EXAMINER'S CERTIFICATE OF DEATH											
1. DECEASED-NAME (Type or Print)			First Middle Last			2a. DATE KNOWN OF DEATH		2b. HOUR			
WALTON			P. WOOLFORD			Month Day Year		12:40 AM			
3. SEX	4. RACE	5. DATE OF BIRTH	6. AGE (In years lost birthday)	IF UNDER 1 YEAR		IF UNDER 24 HRS.		2c. DATE PRONOUNCED DEAD			
M	AA	12-02-14	53 YRS	MONTHS	DAYS	HOURS	MIN	Month Day Year	12:40 AM		
7a. BIRTHPLACE (State or foreign country)		7b. CITIZEN OF WHAT COUNTRY?		8. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/>		9. COUNTY OF DEATH		10. CITY OR TOWN OF DEATH			
Maryland		USA		WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		Wicomico		Salisbury			
11. NAME OF HOSPITAL OR INSTITUTION (If not in hospital give street address)			12a. USUAL OCCUPATION (Kind of work done during most of working life, even if retired)			12b. KIND OF BUSINESS OR INDUSTRY			13. STREET AND NUMBER		
Peninsula General			cook			Campbell Soup			Route 3		
13a. USUAL RESIDENCE (Where deceased lived, if institution: Residence before admission) STATE			13b. COUNTY			13c. CITY OR TOWN			13d. INSIDE CITY LIMITS?		
Md.			Somerset			Princess Anne			YES <input type="checkbox"/> NO <input type="checkbox"/>		
14. FATHER'S NAME			15. MOTHER'S MAIDEN NAME			16a. WAS DECEASED EVER IN U.S. ARMED FORCES?			16b. SOCIAL SECURITY NO.		
James Woolford			Jennie Brice			17. INFORMANT			ADDRESS		
18. CAUSE OF DEATH (Enter only one cause per line for (a), (b), and (c).)			19a. DATE OF OPERATION			19b. CONDITION FOR WHICH OPERATION WAS PERFORMED?			20. AUTOPSY?		
PART 1. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Acute bronchial asthma</u> DUE TO, OR AS A CONSEQUENCE OF (b) <u>473 X</u> DUE TO, OR AS A CONSEQUENCE OF (c) <u>241 X</u>			21a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/>			21b. TIME OF INJURY Month, Day, Year			21c. HOW INJURY OCCURRED (Enter nature of injury in Part 1 or Part 2, Item 18.)		
Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost.			21d. INJURY OCCURRED			21e. PLACE OF INJURY (At home, farm, street, factory, office building, etc.)			21f. LOCATION Street or R.F.D. No. City or Town County State		
22a. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> Inspection <input checked="" type="checkbox"/> Inquiry <input checked="" type="checkbox"/> and in my opinion death resulted from: Natural causes <input checked="" type="checkbox"/> Accident <input type="checkbox"/> Suicide <input type="checkbox"/> Homicide <input type="checkbox"/> Undetermined manner <input type="checkbox"/>			23a. BURIAL, CREMATION, REMOVAL (Specify)			23b. DATE			23c. NAME OF CEMETERY OR CREMATORY		
Burial			8/II/68			Grace			23d. LOCATION (City or Town) (County) (State)		
24. FUNERAL DIRECTOR			25a. REC'D BY REGISTRAR			25b. REGISTRAR'S SIGNATURE			26. DATE		
William H. James Jr			AUG 8 1968			Charles J. J. J.			1968		
Joby James, Princess Anne, Md.											

General Secretary, National Union

VR A15 (4)  
30M REV. 1/6

1888

W. H. Miller